**MEDICAL STAFF BYLAWS**

**OF**

**CANDLER HOSPITAL, INC.**

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# ADOPTION

These Medical Staff Bylaws of Candler Hospital, Inc. (hereinafter the “Bylaws” or “Bylaws of the Medical Staff”) are adopted and made effective upon approval of the Board of Trustees, superseding and replacing any and all previous Bylaws of the Medical Staff, and henceforth all activities and actions of the Medical Staff and each individual exercising clinical privileges at the Hospital shall be taken under and pursuant to the requirements of these Bylaws and the policies and rules and regulations authorized by these Bylaws.

# PREAMBLE

**WHEREAS,** the Board of Trustees recognizes that each physician, dentist, podiatrist, psychologist and appointed to the Medical Staff has responsibility for the exercise of professional judgment in the care and treatment of patients; and

**WHEREAS,** the Board of Trustees, in accordance with legal and accreditation requirements, has delegated to the Medical Staff through its committees and departments, the duties and responsibilities set forth in these Bylaws and the Policies of the Medical Staff including the Organization and Functions Manual and the Medical Staff Rules and Regulations for supervising and monitoring the quality of care provided by physicians, dentists, podiatrists, psychologists and others in the Hospital, and for making recommendation concerning applications for appointment, for reappointment and for clinical privileges;and

**WHEREAS,** the Medical Staff recognizes and accepts its role and responsibilities in the efforts of the Hospital to foster prevention, amelioration and cure of illness, disease and injury, and to provide continuing medical education for Medical Staff members, other health care professionals and patients and their families;

**THEREFORE,** to discharge those duties and responsibilities, and to provide for an orderly process concerning matters of election, meetings, duties and procedures, the officers, committees and departments of the Medical Staff as described in these Bylaws and in the policies authorized by these Bylaws, assume responsibility for fulfilling those duties and functions delegated to them by the Board of Trustees.

# DEFINITIONS

The following definitions shall apply to terms used in these Bylaws:

1. "Board" means the Board of Trustees of Candler Hospital, who have the overall responsibility for the conduct of the Hospital.
2. “Candler,” “Candler Hospital” or “Candler Hospital Medical Staff” means Candler Hospital, Inc. or its medical staff, as the context implies.
3. “Hospital” means Candler Hospital, Inc.
4. “Licensed independent practitioner” means physicians and any other individual permitted by law and by the Hospital to provide care and services without direction or supervision, within the scope of the individual’s license and consistent with individually granted clinical privileges.
5. "MEC" means the Medical Executive Committee of the Medical Staff.
6. "Medical Staff" means all physicians, dentists, podiatrists, psychologists and licensed independent practitioners who are given clinical privileges to treat patients at the Hospital.
7. ”Physicians" means both doctors of medicine ("M.D.s") and doctors of osteopathy ("D.O.s").
8. "Dentist" means a doctor of dental surgery and doctor of dental medicine.
9. “Podiatrist” means a doctor of podiatric medicine.
10. Psychologist” means licensed psychologist.
11. "President of the Hospital" means the individual appointed by the Board to act on its behalf in the overall administration of the Hospital and in granting Medical Staff membership or privileges, or the designee of that person.
12. “President of the Medical Staff” means the person elected to serve as the President of the Medical Staff.
13. “SJ/CHS” means St. Joseph’s/Candler Health System, Inc.
14. “Staff” means members of the Medical Staff.
15. “St. Joseph’s,” “St. Joseph’s Hospital” or “St. Joseph’s Medical Staff” means Saint Joseph’s Hospital, Inc. or its medical staff, as the context implies.
16. Words used in these Bylaws shall be read as the masculine or feminine gender, and as the singular or plural, as the content requires. The captions or headings are for convenience only and are not intended to limit or define the scope or effect of any provision of these Bylaws.

# ARTICLE IPURPOSE

The purpose of the Candler Hospital Medical Staff is to bring the professionals who practice at the Hospital together into a cohesive body to promote good patient care. To this end, among other activities, it will assist in screening applicants for Medical Staff membership, review clinical privileges of Medical Staff and others, evaluate and assist in improving the work done by the Medical Staff, provide education to members of the Medical Staff, other licensed independent practitioners, employees, patients and family members, and offer advice to the President of the Hospital. Because Candler Hospital and St. Joseph’s Hospital, while separate legal entities, are operated together under a Joint Operating Agreement, joint departments and joint committees are performing many of the functions of their respective Medical Staffs. These Bylaws are intended to authorize the Candler Hospital Medical Staff to work in cooperation and coordination with the St. Joseph’s Hospital Medical Staff to achieve efficiencies and enhance the performance of the work done by each organized Medical Staff.

# ARTICLE IIMEDICAL STAFF MEMBERSHIP

## ARTICLE II – PART A: APPOINTMENT

All appointments to the Medical Staff shall be made by the Board pursuant to the provisions of these Bylaws and each appointment shall be to one of the categories of the Staff and one of the departments.

## ARTICLE II – PART B: RIGHTS OF STAFF MEMBERS

### Section 1. The Right to be Heard

Except as may be limited by these Bylaws, each Staff member has the right to an audience with the MEC and/or Credentials committee, as appropriate. In the event the Staff member is unable to resolve an issue through working with his/her department chairperson, the Staff member may, upon presentation of a written notice, meet with the MEC and/or the Credentials Committee as appropriate to discuss the issue.

**ARTICLE II – PART B: RIGHTS OF STAFF MEMBERS**

### Section 2. Initiation of Recall

Any member of the Active Staff has the right to initiate a recall election of a Medical Staff officer or department chairperson. A petition for such recall must be presented, signed by at least 25% of the members of the Active Staff (or 25% of the department’s Active Staff, if applicable). Upon presentation of such valid petition, the MEC will schedule a special general Staff or department meeting for purposes of discussing the issue and, if appropriate, entertain a no-confidence vote.

**ARTICLE II – PART B: RIGHTS OF STAFF MEMBERS**

### Section 3. Call of Staff Meeting

Any member of the Active Staff has the right to initiate the scheduling of a special Staff meeting. Upon the presentation of a petition signed by 25% of the members of the Active Staff, the MEC will schedule a special Staff meeting for the specific purpose addressed by the petitioners. No business other than that in the petition may be transacted.

**ARTICLE II – PART B: RIGHTS OF STAFF MEMBERS**

### Section 4. Challenge to Rule or Policy

Any member of the Active Staff has the right to raise a challenge to any rule or policy established by the MEC. In the event that a rule, regulation or policy is felt to be inappropriate after discussion with the department chairperson and President of the Medical Staff, any member of the Active Staff may submit a petition signed by 25% of the members of the Active Staff. When such petition has been received by the MEC, it will either (1) provide the petitioners with information clarifying the intent of such rule, regulation, or policy and/or (2) schedule a meeting with the petitioners to discuss the issue.

**ARTICLE II – PART B: RIGHTS OF STAFF MEMBERS**

### Section 5. Call of Department/Section Meeting

Any member of the Active Staff has the right to initiate the scheduling of a special Department meeting. Upon the presentation of a petition signed by 25% of the members of the Active Staff of any department or section, the chairperson will schedule a special department meeting for the specific purpose addressed by the petitioners. No business other than that in the petition may be transacted.

**ARTICLE II – PART B: RIGHTS OF STAFF MEMBERS**

### Section 6. Credentialing and Fair Hearing

The rights of all Staff and others applying for or holding Staff appointment, clinical privileges or any other right to practice in the Hospital shall be governed exclusively by these Bylaws and the Fair Hearing Plan that is a part of these Bylaws. Nothing contained in this Article II shall apply to any matter pertaining to an individual’s application for appointment, reappointment or clinical privileges or any recommendation of any individual, department or committee pertaining to any individual’s clinical privileges.

## ARTICLE II – PART C: OBLIGATIONS OF STAFF MEMBERS

Staff members are obligated to work cooperatively to fulfill all obligations of Staff membership referred to in these Bylaws, the Organization and Functions Manual, the Rules of the Medical Staff, all amendments to such documents and all other policies or decisions of the Medical Staff and the Hospital. A complete history and physical examination shall be recorded on the patient’s chart and signed within twenty-four (24) hours following admission. This report shall reflect a comprehensive, current, physical assessment by a doctor of medicine or osteopathy or an appropriate advanced practice professional (Medical Assistant) who has been granted privileges or given permission by the Hospitals to perform histories or physicals. If an advanced practice professional (Medical Assistant) completes the history and physical examination, a doctor of medicine or osteopathy shall authenticate the history and physical examination, taking responsibility for the record being accurate and complete. Medical histories, physical examinations, work-up results, consultations and discharge summaries written/dictated by Physician’s Assistants or Nurse Practitioners shall be signed by the supervising or responsible physician within twenty-four (24) hours following completion. If the patient is admitted solely for oral/maxillofacial surgery, the oral/maxillofacial surgeon may complete the history and physical exam. If the patient comes to the hospital solely for outpatient podiatry surgery, the podiatrist may complete and update the history and physical exam.

## ARTICLE II – PART D: QUALIFICATIONS FOR APPOINTMENT

### Section 1. General

Appointment to the Medical Staff is a privilege that shall be extended only to professionally competent individuals who continuously meet the qualifications, standards, and requirements set forth in these Bylaws and in such policies as are adopted from time to time by the Board. All licensed individual practitioners practicing at the Hospital, unless excepted by specific provisions of these Bylaws, must first have been appointed to the Medical Staff by the Board. All licensed individual practitioners shall be appointed to the Medical Staff of the Hospital and St. Joseph’s Hospital, unless the licensed individual practitioner is providing services to a consolidated service line or the appointment would violate exclusive contractual obligations of Hospital or St. Joseph’s Hospital.

**ARTICLE II – PART D: QUALIFICATIONS FOR APPOINTMENT**

### Section 2. Specific Qualifications

Only physicians, dentists, podiatrists, psychologists and other licensed independent practitioners who satisfy the following conditions shall be qualified for appointment to the Medical Staff:

1. Demonstrate that he/she has successfully graduated from an approved school of medicine, osteopathy or dentistry, an accredited podiatric PSR-24 residency program, or an accredited training program in Psychology;
2. Demonstrate current, unrestricted licensure at initial appointment to practice medicine, osteopathy, dentistry, podiatry, or psychology in the State of Georgia;
3. Demonstrate current DEA registration, as applicable to profession;
4. Demonstrate that he/she has successfully completed an appropriate residency training program approved by the American College of Graduate Medical Education (ACGME) or the American Osteopathic Association (AOA) in the specialty in which he/she seeks privileges. General dentistry applicants must demonstrate successful completion of an accredited one-year general practice residency program. Oral/Maxillofacial surgery applicants must demonstrate successful completion of an ADACDA accredited residency training program in oral and maxillofacial surgery.
5. Demonstrate current Board certification by the appropriate specialty Board (ABMS, AOA, ABPM, ABFAS, ABOMS); or proof that he/she has met the requirements for examination for certification by the appropriate specialty Board. Board certification must be attained within five (5) years of completion of residency/fellowship training or proof of eligibility by the appropriate specialty board. Any applicant who was previously Board certified, but has allowed his/her certification to lapse is not eligible to apply for membership and privileges unless proof of eligibility is provided;
6. Demonstrate evidence of current valid professional liability insurance coverage in the form and amounts as defined by the Board and prior acts coverage;
7. Demonstrate that his/her physical office/residence location is close enough to the Hospital to provide continuous patient care and to fulfill Medical Staff responsibilities or have a firm written agreement with a sponsoring physician/group on the Active staff at the Hospital who is accepting responsibility for continuing of care of his/her patients;
8. Demonstrate recent (within past 12 months) active clinical practice;
9. Explain in writing his/her plans for office location and for using Hospital and St. Joseph’s Hospital;
10. Demonstrates that he/she abides by the ethics or his/her profession and avoids acts and omissions that constitute unprofessional conduct;
11. Demonstrate good reputation and character, including physical and mental health, emotional stability, lack of current abuse of or dependency on drugs or alcohol, and any current treatment for prior abuse or of dependency on drugs or alcohol.
12. Demonstrate that he/she has no record of exclusion or preclusion from participation in federally funded programs such as Medicare or Medicaid;
13. Demonstrate that he/she has no record of conviction of any felony or any misdemeanor related to violence, abuse (child, elder, physical or sexual), controlled substances, illegal drugs or healthcare fraud or abuse.
14. Demonstrate no record of denial, revocation or termination of appointment of clinical privileges by any hospital for reasons related to professional competence or conduct;
15. Demonstrate his/her background, experience, training, current competence, knowledge, judgment, ability to perform and technique in his/her specialty for all requested privileges;
16. Demonstrate the ability to work harmoniously with others in order for all patients treated by him/her to receive safe, quality of care.

Only those applications that meet the above-described qualifications will be processed.

**ARTICLE II – PART D: QUALIFICATIONS FOR APPOINTMENT**

### Section 3. No Entitlement to Appointment

No individual shall be entitled to appointment to the Medical Staff or to the exercise of particular clinical privileges in the Hospital merely by virtue of the fact that such individual (a) is licensed to practice a profession in this or any other state, (b) is a member of any particular professional organization, (c) has had in the past, or currently has, Medical Staff appointment or privileges at any hospital, or (d) resides in the geographic service area of the Hospital as defined by the Board.

**ARTICLE II – PART D: QUALIFICATIONS FOR APPOINTMENT**

### Section 4. Non-Discrimination Policy

The Medical Staff shall not discriminate in granting Membership and/or clinical privileges on the basis of national origin, race, gender, sexual orientation, religion, color, age, veteran status, marital status, disability, unrelated to the provision of patient care or required Medical Staff responsibilities or any other basis prohibited by applicable law.

**ARTICLE II – PART D: QUALIFICATIONS FOR APPOINTMENT**

### Section 5. Ethical & Religious Directives

All Medical Staff appointees and others exercising clinical privileges at Saint Joseph’s Hospital, Inc. shall abide by the terms of the Ethical and Religious Directives for Catholic Health Facilities promulgated by the National Conference of Catholic Bishops with respect to their practice at St. Joseph’s Hospital. No activity prohibited by said Directives shall be engaged in by any Medical Staff appointee or other person exercising clinical privileges at St. Joseph’s Hospital.

## ARTICLE II – PART E: CONDITIONS OF APPOINTMENT

### Section 1. Duration of Initial Appointment

1. All initial appointments to the Medical Staff and all initial grants of clinical privileges shall be for a period of not more than 2 years (24 months). Unless otherwise specified, the term of initial appointment shall be for a period extending to the last day of the individual’s birth month following the first twelve months of the initial appointment.

During the term of this initial appointment, the individual shall be evaluated by the chairperson of the department(s) in which the individual has clinical privileges, and by the relevant committees of the Medical Staff and the Hospital as to the individual's experience, ability and current competence in performing approved privileges; medical/clinical knowledge; practice-based learning and improvement; interpersonal and communication skills; professionalism; systems-based practice and over-all patient care.

**ARTICLE II – PART E: CONDITIONS OF APPOINTMENT**

### Section 2. Duties of Appointees

Appointment to the Medical Staff shall require that each appointee assume such reasonable duties and responsibilities as the Board or the Medical Staff shall require.

## ARTICLE II – PART F: APPLICATION FOR INITIAL APPOINMENT AND CLINICAL PRIVILEGES

### Section 1. Information

Applications for appointment to the Medical Staff shall be submitted electronically to the Medical Staff Office via appropriate credentialing software. The application shall contain a request for staff membership at Hospital and St. Joseph’s Hospital, a request for specific clinical privileges desired by the applicant at Hospital and St. Joseph’s Hospital, and shall require detailed information concerning the applicant's professional qualifications, including:

1. the names, complete mailing addresses, and current email addresses of at least two physicians, dentists, or other practitioners, as appropriate, who have had recent extensive experience in observing and working with the applicant, and who can provide adequate information pertaining to the applicant's present professional competence and character. Said references may not be associated or about to be associated with the applicant in professional practice or personally related to the applicant. At least one reference shall be from the same specialty area as the applicant; the names, complete mailing addresses and current email addresses of the chiefs or chairpersons of each department of any and all hospitals or other institutions at which the applicant has worked or trained (i.e., the individuals who served as chief or chairpersons at the time the applicant worked in the particular department). If the number of hospitals the applicant has worked in is great or if a number of years have passed since the applicant worked at a particular hospital, the Joint Credentials Committee and the Board may take into consideration such factors;
2. information as to whether the applicant's medical staff appointment or clinical privileges have ever been voluntarily or involuntarily relinquished, terminated, limited, denied, revoked, suspended, reduced, or not renewed at any other hospital or health care facility;
3. information as to whether the applicant has ever voluntarily withdrawn his/her application for appointment, reappointment, and clinical privileges, decided not to reapply for appointment and clinical privileges, or resigned from the medical staff before final decision by a hospital's or health care facility's governing board;
4. information as to whether the applicant's membership in local, state, or national professional societies, or license to practice any profession in any state, or Drug Enforcement Administration license is or has ever been suspended, modified, voluntarily or involuntarily terminated, restricted or is currently being challenged. The submitted application shall include a list of all the applicant's licenses in all clinical professions to practice, as well as copies of Drug Enforcement Administration license, medical or dental school diploma, and certificates from all post graduate training programs completed;
5. information as to whether the applicant has ever been excluded by the Federal or a State government from participation in Medicare, State health care programs or other non-procurement programs based on the authority contained in Sections 1128 and 1156 of the Social Security Act.
6. information as to whether the applicant has currently in force professional liability insurance coverage, the name of the insurance company, the amount and classification of such coverage, and whether said insurance coverage covers the clinical privileges the applicant or appointee seeks to exercise;
7. information concerning the applicant's professional liability litigation experience, specifically information concerning final judgments or settlements;
8. information concerning any professional misconduct proceedings and any malpractice actions involving the applicant in this state or any other state, whether such proceedings are closed or still pending, including the substance of the allegations of such proceedings or actions, the substance of the findings of such proceedings or actions, the ultimate disposition of any such proceedings or actions that have been closed, and any additional information concerning such proceedings or actions as the applicant may deem appropriate;
9. an authorization and completed disclosure statement for verification of background and documentation as required by Medical Staff Policy to support the identity of the applicant;
10. a consent to the release of information from the applicant's present and past professional liability insurance carriers;
11. information on the applicant's physical and mental health and emotional stability and ability as it relates to privileges requested, including specifically information indicating current abuse of or dependency on drugs or alcohol and current treatment for prior abuse of or dependency on drugs or alcohol;
12. information as to whether the applicant has ever been named as a defendant in a criminal action and/or convicted of a crime with details about any such instance;
13. information on the citizenship and/or visa status of the applicant;
14. the applicant's signature (original, electronic from a reputable, verifiable source; copy of an original; and/or faxed copy); and
15. such other information as the Board may require.

**ARTICLE II – PART F: APPLICATION FOR INITIAL APPOINTMENT AND CLINICAL PRIVILEGES**

### Section 2. Undertakings and Requirements

 (a) Undertakings:

The following undertakings shall be applicable to every Medical Staff applicant and appointee for staff appointment or reappointment as a condition of consideration of such application and as a condition of continued Medical Staff appointment, if granted:

1. an obligation upon appointment to the Medical Staff to provide continuous care and supervision to all patients within the Hospital for whom the individual has responsibility;
2. an agreement to abide by all bylaws and policies of the Hospital, including all bylaws, rules and regulations of the Medical Staff as shall be in force during the time the individual is appointed to the Medical Staff;
3. an agreement to accept committee assignments and such other reasonable duties and responsibilities as shall be assigned;
4. an agreement to provide, with or without request, new or updated information, (including but not limited to information related to insurance, licensure, criminal arrests or any other action involving a criminal matter) that is pertinent to any question on the application form to the Hospital as it occurs, but no longer than thirty (30) days after occurrence;
5. a statement that the applicant has received and had an opportunity to read a copy of the bylaws of the Hospital, these Bylaws, and the rules and regulations of the Medical Staff as are in force at the time of application, and that the applicant has agreed to be bound by the terms thereof in all matters relating to consideration of the application without regard to whether or not appointment to the Medical Staff and/or clinical privileges are granted;
6. a statement of the applicant's willingness to appear for personal interviews in regard to the application;
7. a statement that the Administrative staff determines to be any misrepresentation or misstatement in, or omission from the application whether intentional or not, shall constitute cause for automatic withdrawal of the application. The processing of the application will not proceed. A new application must be submitted and the applicant must pay a new application fee. In the event that that an appointment has been granted prior to the discovery of such misrepresentation, misstatement or omission, such discovery shall constitute immediate voluntary withdrawal of privileges and voluntary resignation of membership from the Medical Staff. The physician will be notified of the discovery and the result. The physician must make reapplication for staff membership and privileges. A new application fee is required.
8. an obligation (i) to use the Hospital and its equipment sufficient to allow the Hospital, through assessment by appropriate Medical Staff committees and department chairpersons, to evaluate the current competence of the appointee, (ii) or to facilitate and allow the Hospital's access to necessary information from other hospitals where the practitioner is active; and
9. an agreement that the hearing and appeal procedures set forth in these Bylaws shall be the sole and exclusive remedy with respect to any professional review action taken at this Hospital.
10. with regard to any clinical privileges to be exercised at Saint Joseph’s Hospital, Inc., an agreement to abide by the terms of the Ethical and Religious Directives for Catholic Health Facilities promulgated by the National Conference of Catholic Bishops and to perform no activity prohibited by said Directives.

 (b) Requirements

The following requirements shall be applicable to every Medical Staff applicant and appointee for staff appointment or reappointment as a condition of consideration of such application and as a condition of continued Medical Staff appointment, if granted:

1. to refrain from illegal fee splitting or other illegal inducements relating to patient referral;
2. to refrain from delegating responsibility for diagnoses or care of hospitalized patients to any individual who is not qualified to undertake this responsibility or who is not adequately supervised;
3. to refrain from deceiving patients as to the identity of an operating surgeon or any other individual providing treatment or services;
4. to seek consultation whenever necessary;
5. to abide by generally recognized ethical principles applicable to the applicant's profession; and
6. to provide continuous care for patients in the Hospital.

Each applicant for Medical Staff appointment and reappointment shall specifically agree to these undertakings and requirements as part of appointment to the Medical Staff.

**ARTICLE II – PART F: APPLICATION FOR INITIAL APPOINTMENT AND CLINICAL PRIVILEGES**

### Section 3. Burden of Providing Information

1. The applicant shall have the burden of producing information deemed adequate by the Hospital for a proper evaluation of competence, character, ethics and other qualifications, and of resolving any doubts about such qualifications.
2. The applicant shall have the burden of providing such documents as are required by Medical Staff Policy to support the identity of the applicant.
3. Until the applicant has provided all information requested by the Hospital, the application for appointment or reappointment will be deemed incomplete and will not be further processed. Should information provided in the initial application for appointment change during the course of an appointment year, the appointee has the burden to provide information about such change to the Joint Credentials Committee sufficient for the Joint Credentials Committee's review and assessment.

**ARTICLE II – PART F: APPLICATION FOR INITIAL APPOINTMENT AND CLINICAL PRIVILEGES**

### Section 4. Authorization to Obtain Information

The following statements, which shall be included on the application form and which form a part of these Bylaws, are express conditions applicable to any Medical Staff applicant, any appointee to the Medical Staff, and to all others having or seeking clinical privileges at the Hospital. By applying for appointment, reappointment or clinical privileges, the applicant expressly accepts these conditions during the processing and consideration of the application, whether or not appointment or clinical privileges are granted. This acceptance also applies during the time of any appointment or reappointment.

 (a) Immunity:

To the fullest extent permitted by law, the applicant or appointee releases from any and all liability, and extends absolute immunity to the Hospital, its authorized representatives, and any third parties as defined in subsection (d) below, with respect to any acts, communications or documents, recommendations or disclosures involving the applicant or appointee, concerning the following:

1. applications for appointment or clinical privileges, including temporary privileges;
2. evaluations concerning reappointment or changes in clinical privileges;
3. proceedings for suspension or reduction of clinical privileges or for revocation of Medical Staff appointment, or any other disciplinary sanction;
4. summary suspension;
5. hearings and appellate reviews;
6. medical care evaluations;
7. utilization reviews;
8. other activities relating to the quality of patient care or professional conduct;
9. matters or inquiries concerning the applicant's or appointee's professional qualifications, credentials, clinical competence, character, mental or emotional stability, physical condition, drug or alcohol abuse or dependency, ethics or behavior; or
10. any other matter that might directly or indirectly relate to the applicant's or appointee's competence, to patient care, or to the orderly operation of this or any other hospital or health care facility.

 (b) Authorization to Obtain Information:

The applicant or appointee specifically authorizes the Hospital and its authorized representatives to consult with any third party who may have information bearing on the individual's professional qualifications, credentials, clinical competence, character, mental or emotional stability, drug or alcohol abuse or dependency, physical condition, ethics, behavior, or any other matter reasonably having a bearing on the applicant's or appointee's satisfaction of the criteria for initial and continued appointment to the Medical Staff. This authorization also covers the right to inspect or obtain any and all communications, reports, records, statements, documents, recommendations or disclosures of said third parties that may be relevant to such questions. The individual also specifically authorizes said third parties to release said information to the Hospital and its authorized representatives upon request.

 (c) Authorization to Release Information:

The applicant or appointee specifically authorizes the Hospital and its authorized representatives to release such information to other hospitals, health care facilities and their agents, who solicit such information for the purpose of evaluating the applicant's or appointee's professional qualifications pursuant to a request for appointment and/or clinical privileges;

 (d) Definitions:

1. as used in this section, the term "Hospital and its authorized representatives" means the Hospital corporation(s) and any of the following individuals who have any responsibility for obtaining or evaluating the applicant's or appointee's credentials, or for acting upon that individual's application or conduct at the Hospital: the members of its Board and their appointed representatives; the President of the Hospital or his/her designees; other Hospital employees; consultants to the Hospital; the Hospital's attorney and the attorney's partners, associates or designees; and all appointees to the Medical Staff who have any responsibility for obtaining or evaluating the individual's credentials, or for acting upon that individual's application or conduct at the Hospital.
2. as used in this section, the term "third parties" means all individuals, including appointees to the Hospital's Medical Staff and appointees to the Medical Staffs of other hospitals, or other physicians or health practitioners, nurses or other organizations, associations, partnerships and corporations or government agencies, whether hospitals, health care facilities or not, from whom information has been requested by the Hospital or its authorized representatives.

## ARTICLE II – PART G: PROCEDURE FOR INITIAL APPOINMENT

### Section 1. Submission of Application

The application for Medical Staff appointment shall be submitted by the applicant to the President of the Hospital or a designee. It must be accompanied by payment of such processing fees as may be recommended by the Joint Credentials Committee and approved by the Board.

**ARTICLE II – PART G: PROCEDURE FOR INITIAL APPOINTMENT**

### Section 2. Complete Application

1. After reviewing the application to determine that all questions have been answered, reviewing all references and other information or materials deemed pertinent, verifying the information provided in the application with the primary sources or with the American Medical Association ("AMA") Physician Master File, querying and receiving response from the National Practitioner Data Bank, completion of a criminal background verification check, and verification of identity, the application shall be deemed to be complete.
2. An application shall become incomplete if the need arises for new, additional, or clarifying information anytime during the evaluation. Any application that has not been submitted within ninety (90) days of the date that the application was sent to the applicant via credentialing software shall be deemed withdrawn. Any application that continues to be incomplete 30 days after the applicant has been notified of the additional information required shall be deemed to be withdrawn. It is the responsibility of the applicant to provide a complete application, including adequate responses from references. An incomplete application will not be processed.
3. The President of the Hospital or a designee shall post or circulate the name and photograph of the applicant in each Hospital where staff appointment or privileges have been requested so that each Medical Staff appointee may have an opportunity to submit to the Joint Credentials Committee, in writing, information bearing on the applicant's qualifications for staff appointment or clinical privileges. In addition, any current Medical Staff appointee shall have the right to appear in person before the Joint Credentials Committee to discuss in private and in confidence any concerns the appointee may have about the applicant.

**ARTICLE II – PART G: PROCEDURE FOR INITIAL APPOINTMENT**

### Section 3. Department Chairperson Procedure

1. Within thirty (30) days after an application has been deemed complete, the chairperson of each department at Hospital or his/her designee, in which the applicant seeks clinical privileges shall provide the Joint Credentials Committee with a written report concerning the applicant's qualifications for appointment and specific written findings supporting the proposed delineation of the applicant's clinical privileges. This report or reports shall be appended to the Joint Credentials Committee's report. As part of the process of making this report, each department chairperson has the right to meet with the applicant to discuss any aspect of the application, qualifications, and requested clinical privileges. In addition, the chairpersons of all departments where the applicant has requested clinical privileges may confer with each other regarding the applicant's qualifications.
2. The department chairperson, or the individual(s) or committee within the department to which the chairperson has assigned this responsibility, shall evaluate the applicant's education, training, and experience and make inquiries with respect to the same to the applicant's past or current department chairperson(s) or chief(s), and/or the residency training director, and others who may have knowledge about the applicant's education, training, experience, and ability to work with others.
3. The department chairperson shall be available to the Joint Credentials Committee to answer any questions that may be raised with respect to that chairperson's report and findings.
4. Applications which meet the following criteria may be forwarded directly to the Chair of the Joint Credentials Committee, who is empowered to review the application and make a recommendation. The action of the chairperson shall be reported to the Joint Credentials Committee at its next meeting. Applications not meeting the following criteria will be forwarded to the full Joint Credentials Committee: (i) Information on application was verified without difficulty; (ii) References and National Practitioner Data Bank response were obtained without difficulty, indicating no problems; and (iii) No reports of disciplinary action, no license restrictions, no investigations, Nothing negative on criminal background check and nothing to suggest the practitioner is anything other than highly qualified in all areas.

**ARTICLE II – PART G: PROCEDURE FOR INITIAL APPOINTMENT**

### Section 4. Joint Credentials Committee Procedure

1. Within thirty (30) days after receiving the report from the department chairperson(s) or their designee(s), the Joint Credentials Committee or its designee(s) shall examine evidence of the applicant's character, professional competence, qualifications, prior behavior and ethical standing, and shall determine, through information contained in references given by the applicant and from other sources available to the committee, including the report and findings from the chairperson of each clinical department in which privileges are sought, whether the applicant has established and satisfied all of the necessary qualifications for appointment and for the clinical privileges requested.
2. As part of the process of making its recommendation, the Joint Credentials Committee may require a physical and/or mental examination of the applicant by a physician or physicians satisfactory to the Joint Credentials Committee and shall require that the results be made available for the committee's consideration. Failure of an applicant to procure such an examination within six weeks after being requested to do so in writing by the Joint Credentials Committee shall constitute a voluntary withdrawal of the application for appointment and clinical privileges, and all processing of the application shall cease.
3. The Joint Credentials Committee shall have the right to require the applicant to meet with the committee to discuss any aspect of the applicant's application, qualifications, or clinical privileges requested.
4. The Joint Credentials Committee may use the expertise of any department chairperson, or any member of the department(s), or an outside consultant, if additional research is required into the applicant's qualifications.
5. If, after considering the report(s) of the clinical department chairperson(s) concerned, the Joint Credentials Committee's recommendation for appointment is favorable, the Joint Credentials Committee shall recommend department assignment. All recommendations to appoint must specifically recommend the clinical privileges to be granted, which may be qualified by any probationary or other conditions or restrictions.
6. If the recommendation of the Joint Credentials Committee is delayed longer than 90 days, the Chairperson of the Joint Credentials Committee shall send a letter to the applicant, with a copy to the MEC and to the President of the Hospital, explaining the reasons for the delay.

**ARTICLE II – PART G: PROCEDURE FOR INITIAL APPOINTMENT**

### Section 5. Favorable Joint Credentials Committee Recommendation and MEC Review

1. If the Joint Credentials Committee's recommendation is to appoint the applicant and to grant the requested clinical privileges, it shall send its recommendations and written findings in support thereof to the MEC. If the recommendation of the MEC s favorable, the application shall be forwarded to a subcommittee of the Board which shall be comprised of at least two Board designees who are voting members of the Board who have been authorized and empowered by the Board to make appointments and grant privileges. Action taken by the subcommittee(s) shall be reported to the Board at their next regularly scheduled meeting.
2. If after reviewing the Joint Credentials Committee’s recommendation, the MEC does not support the Joint Credentials Committee’s recommendation, they may (1) send any recommendation of the Joint Credentials Committee or its designee back to the Joint Credentials Committee for further review, or (2) recommend against approval of the recommendation of the Joint Credentials Committee or its designee.
3. Applications meeting the following criteria are not eligible for expedited approval as provided for in Part H, Article II and shall be forwarded by the MEC to the Board;
4. The applicant submitted an incomplete application;
5. There is a current challenge or a previously successful challenge to licensure or registration;
6. There has been a final judgment adverse to the applicant in a professional liability action; or
7. The MEC made a final recommendation that is adverse or with limitations.
8. If, at any time, the recommendation is unfavorable and would entitle the applicant to request a hearing pursuant to these Bylaws, it shall be forwarded to the President of the Hospital who shall promptly so notify the applicant in writing, certified mail, return receipt requested. The applicant shall then have an opportunity to exercise the right to a hearing and appeal as provided in these Bylaws.
9. Upon receipt of a favorable recommendation from the Joint Credentials Committee or its designee and favorable review and comment by the MEC, that the applicant be granted appointment and the requested clinical privileges, the Board or its subcommittee may:
10. appoint the applicant and grant clinical privileges as recommended; or
11. refer the matter to either MEC, the Joint Credentials Committee or to another source inside or outside the Hospital for additional research or information; or
12. reject the recommendation.
13. If the Board or its subcommittee determines to reject the favorable recommendation of the Joint Credentials Committee and the favorable review by the MEC, it should first discuss the matter with the chairperson of those committees, or it may refer the matter back to either committee for further research, evaluation and recommendation or to another source inside or outside the Hospital. If the Board's determination remains unfavorable to the applicant, that determination and the reasons in support thereof, shall be sent to the President of the Hospital, who shall promptly so notify the applicant in writing, certified mail, return receipt requested. The Board shall make no final decision until the applicant has had an opportunity to exercise the right to a hearing and appeal as provided in these Bylaws.

**ARTICLE II – PART G: PROCEDURE FOR INITIAL APPOINTMENT**

### Section 6. Unfavorable Joint Credentials Committee Recommendation

If the Joint Credentials Committee's recommendation is unfavorable and would entitle the applicant to request a hearing pursuant to these Bylaws, it shall be forwarded to the President of the Hospital who shall promptly so notify the applicant in writing, certified mail, return receipt requested. The applicant shall then have an opportunity to exercise the right to a hearing and appeal as provided in these Bylaws.

**ARTICLE II – PART G: PROCEDURE FOR INITIAL APPOINTMENT**

### Section 7. Favorable Joint Credentials Committee Recommendation and Unfavorable MEC Review

If the Joint Credentials Committee's recommendation is to appoint the applicant and to grant the requested clinical privileges, but the review of the MEC is unfavorable and would entitle the applicant to request a hearing pursuant to these Bylaws, the MEC shall set forth in its comment clear and convincing reasons, along with supporting information, for its changes and forward its comments together with the Joint Credentials Committee's findings and recommendations to the Board. Thereafter, the Board or the President of the Hospital shall meet with the Chairpersons of the Joint Credentials and MECs to see if the disagreement in recommendations can be resolved. After that meeting:

1. If the Board, after informal discussion, is inclined to take action that would entitle the applicant to request a hearing pursuant to these Bylaws, it shall inform the President of the Hospital who shall promptly so notify the applicant in writing, return receipt requested, and make no decision until the applicant has had an opportunity to exercise the right to a hearing and appeal as provided in these Bylaws;
2. If the Board determines to appoint the applicant and grant requested clinical privileges, that decision shall be final;
3. If the Board wishes further study to resolve the difference in recommendation by the Joint Credentials Committee and the findings by the MEC, it may refer the application to either committee for further research, investigation and recommendation or to another source inside or outside the hospital. Upon receipt of such further information, the Board shall proceed as outlined in (a) or (b) of this subpart.

## ARTICLE II – PART H: CLINICAL PRIVLEGES

### Section 1. General

1. Medical Staff appointment or reappointment as such shall not confer any clinical privileges or right to practice at Hospital. Each individual who has been appointed to the Medical Staff of Hospital shall be entitled to exercise only those clinical privileges specifically granted by the Board. In addition, all individuals who are permitted by law and by Hospital to provide professional patient care services independently in the Hospital shall have delineated clinical privileges whether or not they are members of the medical staff.
2. The grant of clinical privileges shall carry with it acceptance of the obligations of such privileges including emergency department and other rotational obligations, and clinical privileges shall be voluntarily relinquished only in the manner that provides for the orderly transfer of such obligations.
3. The exercise of clinical privileges within any department of Hospital is subject to the rules and regulations of that department and to the authority of the department chairperson.
4. The clinical privileges recommended to the Board, whether initial clinical privileges or renewal thereof, shall be based upon consideration of the following:
5. the applicant's education, training, documented experience in categories of treatment areas or procedures, demonstrated current competence and judgment, references, utilization patterns, current knowledge and skills, quality of care; results of care; the conclusions drawn from organizational performance improvement activities, when available; and physical and mental health status and ability as it relates to privileges requested, including specifically any indication of current drug or alcohol abuse or dependency;
6. availability of qualified physicians or other appropriate appointees to provide medical coverage for the applicant in case of the applicant's illness or unavailability;
7. adequate levels of professional liability insurance coverage with respect to the clinical privileges requested;
8. the Hospital's available resources and personnel;
9. any previously successful or currently pending challenges to any licensure or registration, (including but not limited to any state district or Drug Enforcement Administration) or the voluntary or involuntary relinquishment of such licensure or registration,
10. information concerning any voluntary or involuntary termination of Medical Staff appointment or voluntary or involuntary limitation, reduction, or loss of clinical privileges at another hospital;
11. the applicant’s participation in continuing education; and
12. other relevant information, including a written report and findings by the chairperson of each of the clinical departments in which such privileges are sought.
13. The following conditions must be met for request of privileges requiring proctored cases:
14. Unless otherwise specified in the privilege criteria, all proctored cases should be obtained within six (6) months of the conditional approval for the privilege.
15. All proctored cases must be done in an acute care hospital setting.
16. If the proctored cases are not or cannot be completed in the six (6) month time frame, an extension of the proctoring period may be requested from the Joint Credentials Committee, and
17. If the proctored cases are not completed in the six (6) month time frame and an extension is either not requested or is not granted, the request for privilege is considered voluntarily withdrawn.
18. Physicians requesting privileges with separate/additional criteria requiring proctored cases must be approved to perform said proctored cases by the Joint Credentials Committee, MEC and the Board after a review of all other requirements (e.g. education, training, letter of request for full privileges, etc.). Upon completion of the required proctored cases, physician may receive conditional approval of the clinical privileges under the following process:
19. Within 3 working days, after all requirements as stated in the criteria for the privileges are met, including the completion of the required number of proctored cases, and submitted to the Medical Staff Services office, the chairperson of the department at Hospital, as appropriate, or his/her designee, in which the applicant seeks the new clinical privilege, shall review the request and all appropriate documents and make recommendation to the Joint Credentials Committee concerning the applicants qualifications of the new privilege.
20. Within 5 working days after all requirements as stated in the criteria for the privilege are met and submitted to the Medical Staff Services office, applications which meet the following criteria may be forwarded directly to the Chair of the Joint Credentials Committee, with or without the department chairperson review and recommendation, who is empowered to review the application and make a recommendation for conditional approval of privileges, which allows the physician to begin performing the procedure, while awaiting final review by the full Joint Credentials committee, MEC, and Board. The action of the chairperson shall be reported to the Joint Credentials Committee at its next meeting for review and recommendation. Applications not meeting the following criteria will not be eligible for conditional approval and will be forwarded to the full Joint Credentials Committee for review and recommendation:
	1. All documents required in the privilege criteria were submitted to the Medical Staff Services office;
	2. All proctor forms were received and complete;
	3. The proctor has rated the physician “Acceptable” or “Outstanding” in all proctored cases and has not indicated any complication or adverse event; and
	4. Evidence is available that all proctored cases have been reviewed through the Medical Staff quality process and there were no complications pre, intra, or post procedure.
21. After the Chair of the Joint Credentials Committee and President of Medical Staff or designee, as representative of MEC, review and recommend conditional approval, the file, including all documents and all recommendations are reviewed by the President of the Hospital or designee and approval or denial of the conditional privileges shall be made.
22. All actions of the expedited approval process are reported to the next meeting of the Joint Credentials Committee and MEC for review and recommendation and to the Board for final approval or denial.
23. The process, as described in Part G, Article II of these Bylaws, will be followed for further review and recommendation.
24. The physician being proctored cannot schedule, perform or participate in any additional procedures until such time as he/she is notified of conditional approval of privileges. Physician will be notified of the final decision regarding privileges following review and recommendation by the Joint Credentials Committee and MEC and the review and approval or denial by the Board.
25. The reports of the chairperson(s) of the clinical department(s) in which privileges are sought shall be forwarded to the Joint Credentials Committee and processed as a part of the initial application for staff appointment.

**ARTICLE II – PART H: CLINICAL PRIVILEGES**

### Section 2. Clinical Privileges for Dentists

1. The scope and extent of surgical procedures that a dentist may perform at Hospital shall be delineated and recommended in the same manner as other clinical privileges.
2. Surgical procedures performed by dentists shall be under the overall supervision of the Chairperson of the Department of Surgery. A medical history and physical examination of the patient shall be made and recorded by a physician who holds an appointment to the Medical Staff before dental surgery shall be scheduled for performance, and a designated physician shall be responsible for the medical care of the patient throughout the period of hospitalization.
3. Qualified oral and maxillofacial surgeons who admit patients without underlying health problems may perform a complete admission history and physical examination and assess the medical risks of the procedure on the patient if they are deemed qualified to do so by the Joint Credentials Committee. "Qualified oral and maxillofacial surgeons" shall be interpreted to refer to licensed dentists who have successfully completed a post-graduate program in oral surgery accredited by a nationally recognized accrediting body approved by the United States Office of Education.
4. The dentist shall be responsible for the dental care of the patient, including the dental history and dental physical examination as well as all appropriate elements of the patient's record. Dentists may write orders within the scope of their license and consistent with the bylaws, policies, rules or regulations of the Hospital, the Board or Medical Staff.

**ARTICLE II – PART H: CLINICAL PRIVILEGES**

### Section 3. Interns and Residents

Interns and residents in training at a Hospital shall not hold appointments to the Medical Staff and shall not be granted specific clinical privileges. Rather, they shall be permitted to exercise only those privileges determined by their sponsor, appropriate Department Chairperson, and Chairperson of the Joint Credentials Committee.

**ARTICLE II – PART H: CLINICAL PRIVILEGES**

### Section 4. Clinical Privileges for Podiatrists

1. The scope and extent of surgical procedures that a podiatrist may perform at Hospital shall be delineated and recommended in accordance with the provisions of the policies governing such practitioners as may be adopted by the Board from time to time.
2. Surgical procedures performed by podiatrists shall be under the overall supervision of the Chairperson of the Department of Surgery. A medical history and physical examination of each patient confirming or endorsing the findings, conclusions and assessment of risk shall have taken place and been recorded in the medical record by a physician who holds an appointment to the Medical Staff before major high-risk podiatric surgery (as determined by the Medical Staff) shall be performed, and a designated physician shall be responsible for the medical care of the patient during hospitalization.
3. The podiatrist shall be responsible for management of the podiatric care of the patient, including the podiatric history and the podiatric physical examination as well as all appropriate elements of the patient's record. Podiatrists may write orders which are within the scope of their license and consistent with the bylaws, policies, rules or regulations of the Hospital, the Board and Medical Staff.

**ARTICLE II – PART H: CLINICAL PRIVILEGES**

### Section 5. Clinical Privileges for Other Medical Staff Members

1. The scope and extent of clinical Privileges that may be granted to all other practitioners who qualify for membership to the Medical Staff shall be delineated and recommended in the same manner as other clinical privileges.
2. The Department of Medicine shall determine the appropriate scope of clinical privileges for psychologists and its chairperson shall review their individual applications for clinical privileges and report in the same manner as for physicians.
3. Other members of the Medical Staff may perform all or part of the medical history and physical examination in accordance with the privileges granted.
4. The findings, conclusions and assessment of risk are confirmed or endorsed by a qualified physician prior to major high-risk (as defined by the Medical Staff) diagnostic or therapeutic interventions.
5. Management of a patient’s general medical conditions is the responsibility of a qualified physician member of the Medical Staff.

**ARTICLE II – PART H: CLINICAL PRIVILEGES**

### Section 6. Clinical Privileges for Contract Physicians

The staff appointment and clinical privileges of any Medical Staff member who has a contractual relationship with a Hospital, or is either an agent, employee, or principal of, or partner in, an entity that has a contractual relationship with a Hospital, relating to providing services to patients at a Hospital, shall be covered under the same credentialing criteria for privileges as any other physician applying for staff appointment or clinical privileges. However, unless otherwise prohibited by law, any waiver of a staff member's rights to a hearing and appeal regarding staff appointment and/or clinical privileges contained in a contract signed by the person granted staff appointment and/or clinical privileges shall be binding upon such person and shall supersede any rights contained in these Bylaws.

**ARTICLE II – PART H: CLINICAL PRIVILEGES**

### Section 7. Procedures for Requesting Proctor Privileges

1. Request to Serve as Proctor:

Any qualified physician seeking to serve as proctor to a current medical staff appointee through participation in direct patient care shall be responsible for submitting a completed application form approved by the Board. Application packages will be mailed to the applicant upon request. Appointment shall be for a specified time period as deemed necessary to complete the proctorship. Proctors who intend to observe only, with no direct participation in patient care, are exempt from this requirement.

1. Factors to be Considered:
	1. Applicant’s specialty, qualifications and current competency to perform procedure for which he/she will serve as proctor.
	2. Current status of physician who will be proctored. Must be an active member in good standing at Hospital.
	3. Physician must have also fulfilled the basic requirements for requesting additional privileges.
2. Application:

Applications to serve as Proctor shall be reviewed by the Medical Staff and Hospital. Those applications which meet the following criteria are deemed complete:

* 1. Complete information provided on application;
	2. For cases in which a proctor may provide medical treatment, including, but not limited to, participating in the surgical plan, manipulation of instruments and/or being ‘scrubbed’ in, a copy of current Georgia medical license is provided; for cases in which the proctor will not provide medical treatment, a copy of an appropriate current license is provided;
	3. Copy of current professional liability insurance coverage;
	4. Practitioner-specific profile, Data Bank report and malpractice data obtained without difficulty, indicating no problematic trends or patterns;
	5. Letters of good standing from current facilities where applicant practices;
1. Verification:
	1. AMA profile will be obtained and used for education verification;
	2. The appropriate license as indicated in (c) 2, will be verified with the Composite State Board of Medical Examiners or other appropriate agency in the case of a foreign proctor;
	3. National Practitioner Data Bank will be queried;
	4. Letter from current hospital verifying qualifications and good standing will be requested.
2. Approval:
	1. The Department Chairman for the applicable department shall review and provide a report concerning the applicant’s qualifications for approval as proctor to the President of the Medical Staff. The President of the Medical Staff shall make a recommendation to the President of the Hospital or designee and the Board Representative who must approve the granting of privileges for an individual requesting privileges to serve as a proctor for a medical staff member in good standing.
	2. Appointment for a specified time period as deemed necessary to complete the proctorship.
	3. Any such approval is reported at the next Joint Credentials Committee, Medical Executive Committee and Board.
	4. The President of the Hospital may, at any time after receiving a recommendation from the President of the Medical Staff or the chairperson of the department responsible for the individual’s supervision, terminate the proctoring privileges.
	5. The granting of proctoring privileges is a courtesy on the part of the Hospital. Excluding the termination or limitation of such privileges for demonstrated incompetence or unprofessional conduct, neither the granting, denial, nor termination of such privileges shall entitle the individual concerned to any of the procedural rights provided in these Bylaws with respect to hearings or appeals.

## ARTICLE II – PART I: VOLUNTARY RELINQUISHMENT OF PRIVILEGES

### Section 1. Request to Relinquish Clinical Privileges

1. A Medical Staff appointee who desires to voluntarily relinquish any one or more of the clinical privileges granted at any time during the appointment period may submit a written request to the Chairperson of the Joint Credentials Committee specifying the clinical privilege(s) to be relinquished. Said relinquishment of privileges shall not be effective until acknowledged in writing by the Board of the Hospital.
2. The procedure set forth in this Part shall not apply to situations where the appointee has been deemed by Hospital to have voluntarily relinquished privileges pursuant to these Bylaws, rules and regulations of the Medical Staff, the Hospital bylaws or policies, or a contract between the appointee and the Hospital.
3. Voluntary relinquishment of clinical privileges while under an investigation or in exchange for not conducting an investigation shall be considered a "surrender" of such privileges and shall be so reported where appropriate and when so required.

**ARTICLE II – PART I: VOLUNTARY RELINQUISHMENT OF PRIVILEGES**

### Section 2. Procedure for Relinquishment of Clinical Privileges

1. Within sixty (60) days of receiving a request to relinquish one or more clinical privileges, the Joint Credentials Committee shall review the request and forward a recommendation to the Board for final action. The Joint Credentials Committee may request a meeting with the appointee involved if the decrease of the clinical privileges would create a deficiency in available hospital services. A report of such meeting shall be submitted with the Joint Credentials Committee's recommendation to the Board.
2. The Board shall act on the request and its decision shall be reported in writing by the President of the Hospital to the appointee, the Joint Credentials Committee, and the chairperson of the applicable department(s). The decision of the Board shall specify a specific date by which relinquishment of clinical privilege(s) shall become effective.
3. Failure to relinquish any clinical privilege pursuant to Sections 1 and 2 of this Part or to adhere to the effective date specified by the Board for the relinquishment of the clinical privileges in question shall constitute grounds for professional review action pursuant to of these Bylaws.

## ARTICLE II – PART J: PROCEDURE FOR TEMPORARY CLINICAL PRIVLEGES

### Section 1. Temporary Clinical Privileges

Temporary privileges shall not routinely be granted to applicants. Temporary privileges may be granted on a case-by-case basis when there is an important patient care need that mandates an immediate authorization to practice. Temporary privileges may also be granted when a new applicant is waiting for approval by the Medical Executive Committee or the Board of Trustees, provided that the applicant: (i) has provided a complete application with no concerns; (ii) has no current or previously successful challenge to licensure or registration; (iii) has not been subject to involuntary termination of medical staff membership at another hospital or organization; and (iv) has not been subject to involuntary limitation, reduction, denial, or loss of clinical privileges. The President of the Hospital or other person authorized by the Board, may, after completion of all procedures required by these Bylaws through a favorable recommendation from the Department Chairperson, Joint Credentials Committee or its Chairperson, as applicable, and President of the Medical Staff, grant temporary appointment and temporary admitting and clinical privileges to an applicant for ninety (90) days. A thirty (30) day extension may be granted, but only under extenuating circumstances. In exercising such privileges, the applicant shall act under the supervision of the Chairperson or appropriate designee of the department(s) in which the applicant has requested primary privileges. Temporary privileges will not be granted for administrative expediency.

**ARTICLE II – PART J: PROCEDURE FOR TEMPORARY CLINICAL PRIVILEGES**

### Section 2. Special Requirements

Special requirements of supervision and reporting may be imposed by the department chairperson concerned on any individual granted temporary clinical privileges. Temporary privileges shall be immediately terminated by the President of the Hospital or a designee upon notice of any failure by the individual to comply with such special conditions.

**ARTICLE II – PART J: PROCEDURE FOR TEMPORARY CLINICAL PRIVILEGES**

### Section 3. Locum Tenens

1. The President of a Hospital, or other authorized person, may grant an individual serving as a locum tenens for an appointee of the Medical Staff temporary admitting and clinical privileges to attend patients of a specific appointee. The applicant for locum tenens must complete an application and privilege request as described in Article II, Part F and shall include funds equivalent to one (1) year of Medical Staff dues to cover the cost of application processing and funds to cover a criminal background search. Primary source verification and processing of the application will be done as with any new applicant as described in Article II, Part G. The applicant must have a signed acknowledgment that the individual has received and had the opportunity to read a copy of these Bylaws and the rules and regulations of the Medical Staff which are then in force and agrees to be bound by the terms thereof in all matters relating to temporary clinical privileges.
2. The applicant may be granted temporary privileges for up to one year but may not provide locum tenens service for more than 30 consecutive days at a time.
3. Each period of time the physician is to be used for locum tenens coverage, the Medical Staff office is to be notified with enough time to complete the modified verification to include NPDB, license, insurance and sanctions. If no adverse information is identified, the physician may work without further review and approval.
4. If adverse information is identified, the information is brought to the attention of the Department Chairman, Joint Credentials Chairman and VPMA for review and recommendation.
5. The locum tenens applicant will not be granted privileges exceeding the privileges of the appointee for whom they are covering.
6. Locum tenens providers are not required to meet meeting requirements but may attend department and general staff meetings for information and education.
7. At the end of the one-year appointment period, if the applicant plans to continue to provide locum tenens service, a reappointment application is completed and processed with request for references from the places worked within the last year. The approval process through the department chair, Joint Credentials Committee, MEC and Board will be followed.
8. Annually, the quality of care and competency is evaluated for care provided within the Hospital. If there is not enough data to review quality of care and competency, the burden is on the applicant to provide resources for this data.
9. If approved, an additional year of appointment is assigned. The Medical Staff office must continue to be notified each time the applicant is to work as locum tenens and modified verification of NPDB, license, insurance and sanctions are reviewed. The process will follow as described in (c) and (d).
10. A locum tenens applicant will not be eligible for promotion to active status unless applicant relocates to the area and meets all criteria as described for active status.
11. Failure of a physician holding temporary privileges to comply with these Bylaws, the rules and regulations of the Medical Staff, or if quality of care so warrants as determined by the President of the Hospital based upon the review and recommendations of the Joint Credentials Committee and MEC, the physician’s privileges shall be deemed automatically withdrawn.
12. Physicians providing locum tenens coverage are members of the Medical Staff and practice at the discretion of the Board and thus are covered by the due process provisions of these Bylaws.

**ARTICLE II – PART J: PROCEDURE FOR TEMPORARY CLINICAL PRIVILEGES**

### Section 4. Mastery in General Surgery Program (MGSP)

Mastery in General Surgery Program (MGSP) in General Surgery was developed by the American College of Surgeons (“ACS”). The program is designed to give surgeons who have completed residency and/or fellowship and entering the practice of general surgery to fill gaps in training and to get help to transition to independent practice in general surgery.

1. MGSP applicants must be accepted by an ACS approved medical group with membership and privileges at Hospital.
2. MGSP applicants must make application and meet all medical staff requirements as outlined in these Bylaws for the approval of one (1) year membership and privileges.
3. For the first year, the applicant will work under the direct supervision of their sponsor group to make rounds, document the medical record, take call, and obtain surgical experience.
4. At the end of the one (1) year appointment, the applicant will be evaluated by the MGSP sponsoring medical group. If there are plans for the MGSP physician to continue to practice at Hospital, the MGSP applicant must reapply and go through the review and approval process for membership and privileges at Hospital.

**ARTICLE II – PART J: PROCEDURE FOR TEMPORARY CLINICAL PRIVILEGES**

### Section 5. Termination of Temporary Clinical Privileges

1. The President of the Hospital may, at any time after receiving a recommendation from the President of the Medical Staff or the chairperson of the department responsible for the individual's supervision, terminate temporary admitting privileges. Clinical privileges shall then be terminated when the individual's inpatients are discharged from the Hospital. However, where it is determined that the care or safety of such patients would be endangered by continued treatment by the individual granted temporary privileges, a summary termination of temporary clinical privileges may be imposed by the President of the Hospital, the department chairperson, or the President of the Staff, and such termination shall be immediately effective.
2. The appropriate Department Chairperson or the President of the Medical Staff shall assign to a Medical Staff appointee responsibility for the care of such terminated individual's patients until they are discharged from the Hospital, giving consideration wherever possible to the wishes of the patient in the selection of the substitute.
3. The granting of any temporary admitting and clinical privileges is a courtesy on the part of the Hospital. Excluding the termination or limitation of such privileges for demonstrated incompetence or unprofessional conduct, neither the granting, denial, or termination of such privileges shall entitle the individual concerned to any of the procedural rights provided in these Bylaws with respect to hearings or appeals.

## ARTICLE II – PART K: EMERGENCY/DISASTER CLINICAL PRIVLEGES

### Section 1. Emergency Clinical Privileges

1. For the purposes of this section, an "emergency" is defined as the condition which could result in serious or permanent harm to a patient(s) and in which any delay in administering treatment would add to that harm or danger. All other conditions are considered "non-emergent".
2. In an emergency, a physician currently appointed to the Medical Staff may be permitted by a Hospital to act in such emergency by exercising clinical privileges not specifically granted to that appointee. When the emergency situation no longer exists, such physician must request the temporary privileges necessary to continue to treat the patient. In the event such temporary privileges are denied or not requested, the patient shall be assigned by the President of the Medical Staff to an appointee of the staff with selection of a substitute physician.

**ARTICLE II – PART K: EMERGENCY/disaster CLINICAL PRIVILEGES**

### Section 2. Credentialing for Disaster and/or Mass Casualty

1. In a disaster, a physician who is not currently appointed to the Medical Staff may be permitted by the Hospital to exercise clinical privileges.
	1. For the purpose of this section, “disaster” is defined as a situation of disaster and/or mass casualty that requires the activation of the Emergency Management Plan and the Hospital is unable to handle immediate patient-care needs.
2. Approval Process:
	1. When the Emergency Management Plan is activated and the Hospital is unable to manage immediate patient-care needs, the President of the Hospital or the Vice President of Medical Affairs is responsible for granting emergency privileges for licensed independent practitioners (LIP) who may volunteer for service in the Hospital.
	2. In the absence of the President of the Hospital or the Vice President of Medical Affairs, the following Medical Staff officers are designated to grant emergency privileges: (i) President of the Medical Staff of Hospital or St. Joseph’s Hospital; and Co-Chair(s) of the Joint Credentials Committee.
	3. Approval is granted on a case-by-case basis, specialty-specific and time-limited after key identification documents are received. Volunteer LIP(s) cannot carry out any clinical activities for which they do not already hold privileges at another hospital or institution.
	4. The volunteer LIP will complete the Emergency Check Off Credentialing List with his/her name, license number (if available), social security number, date of birth and practice specialty.
	5. After the volunteer LIP has been approved to practice by one of the designated persons, the LIP will be assigned to a specialty department and will be assigned to work under the direction of a member of that department who is a member of the Medical Staff.
	6. Privileges for volunteer LIP(s) are terminated when the President of the Hospital or his designee makes the official declaration that the emergency is over.
3. Key Identification Documents
4. Current U.S. medical license and a valid picture identification issued by a state, federal, or regulatory agency (e.g., a driver’s license or passport) and at least one of the following: (i) current hospital photo identification card; (ii) identification that certifies the individual is a member of a disaster medical assistance team (DMAT)[[1]](#footnote-1), the Medical Reserve Corp (MRC), the Emergency System for Advance Registration of Volunteer Health Professionals (ESAR-VHP), or other recognized State or Federal response organization or group; (iii) identification that certifies a state, federal or municipal entity has granted the individual the authority to administer patient care under emergency circumstances. Such IDs include those held by the Federal Emergency Management Agency (FEMA) personnel and the state medical examiner. These badges include the cardholder’s name, picture and a bar code; or (iv) confirmation by a current hospital or Medical Staff member who is able to confirm the practitioner’s identity and ability to act as a licensed independent practitioner.
5. Identification Methods
	1. If the physician photo badge equipment in the Medical Staff Services office is operable, a photo ID is made with designation of Emergency Personnel.
	2. If the photo badge equipment is not operable, a special armband will be used to identify the volunteer LIP(s). The armband will specify name and specialty.
	3. A flyer or electronic message will be distributed throughout the organization that includes the names of, basic demographic information about and list of privileges granted to the volunteer LIP(s).
6. Monitoring of Patient Care
	1. To monitor the care provided by the volunteer LIP(s) granted emergency privileges, a list of all patients treated will be kept by the practitioner and the physician designated as a proctor.
	2. The physician proctor will be responsible for monitoring the quality of care provided concurrently through either director observation, or medical record review. If a question of competency or quality of care is identified, the incident(s) is (are) reported to the authorities responsible for approving emergency privileges for action.
	3. Retrospectively, within 72 hours of the volunteer LIP’s arrival, all cases in which care was rendered by volunteer LIP(s) are reviewed for patterns and trends in quality of care to determine if disaster privileges should continue.
7. Privilege Verification
	1. As soon as the immediate disaster is under control, or within 72 hours of the volunteer LIP’s arrival, credentials for the volunteer LIP(s) must be verified. Verification will include licensure, sanctions and National Practitioner Data Bank. If primary source verification cannot take place within 72 hours of LIPs arrival due to extraordinary circumstances, it will be done as soon as possible and the Hospital will document all of the following: (i) reason(s) it could not be performed within 72 hours of LIPs arrival; (ii) evidence of the LIPs demonstrated ability to continue to provide adequate care, treatment and services; and (iii) evidence of the Hospital’s attempt to perform primary source verification as soon as possible.
	2. If discrepancies and/or issues are identified during the verification process for the volunteer LIP(s), these should be brought to the attention of the Department Chairperson and Co-Chair(s) of the Joint Credential Committee.
	3. Emergency privileges may be terminated by the President of the Hospital or a designee if discrepancies are identified during the verification process or failure of the individual to comply with special conditions of proctoring and monitoring are not met.

## ARTICLE II – PART L: TELEMEDICINE

### Section 1. Telemedicine

1. Telemedicine is defined as the use of medical information exchanged from one site to another via electronic communications for the health and education of the patient or health care provider and for the purpose of improving patient care, treatment and services.
2. The Medical Staffs at both originating (where the patient is located) and distant sites (site where the Licensed Independent Practitioner [LIP] providing the service is located) recommend the clinical services be provided by LIPs through a telemedicine link at their respective sites.
3. The telemedicine services that are provided must be consistent with commonly accepted measures of the quality for such services.
4. The MEC must recommend, and the Board approve, the scope of the telemedicine services provided in the Hospital.
5. These services are narrowly defined, focusing solely on LIPs who have either total or shared responsibility for patient care, treatment and services (as evidenced by having the authority to write orders and direct patient care, treatment and services) through a telemedicine link.
6. LIPs who provide reading of images, tracings or specimens through a telemedicine link (interpretive services) must do so under one of the following two arrangements: (i) the LIP applies for and is granted clinical privileges at Hospital in accordance with the Hospital credentialing and privileging process as governed by these Bylaws and the polices, rules and regulations of the Medical Staff; and (ii) the Hospital or a physician member of the Medical Staff contracts for the provision of these services by the LIP. These services to be provided must be consistent with existing Hospital and Medical Staff policies addressing contracted services.
7. In the reappointment process for telemedicine providers, because these LIPs are customarily credentialed in multiple facilities, it is permissible to verify references in a sampling manner. A minimum of ten percent (10%) of the facilities will be verified biannually in a rotating manner (a different 10% will be queried every reappointment cycle.)
8. LIPs credentialed for telemedicine, do not have physical patient and co-worker contact, therefore an exemption from providing documentation of tuberculin and influenza vaccination will be allowed.
9. If the Hospital has a pressing clinical need and a LIP can provide the service through a telemedicine link, the Hospital may evaluate the use of temporary privileges as outlined these Bylaws for this clinical situation.
10. Consultative services via telemedicine (services provided by the LIPs for the sole purpose of offering an expert opinion to and/or advising the treating practitioner but not directing the patient’s care) are not subject to the credentialing and privileging process.
11. Oversight of the patient care, treatment and services provided are subject to policies and procedures of peer review and continuous monitoring for patient safety and performance improvement.
12. LIPs providing care, treatment and services via telemedicine are encouraged but not required to comply with the General Staff and Department meeting requirements.

# ARTICLE III

# ACTIONS AFFECTING MEDICAL AND DENTAL STAFF APPOINTEES

## ARTICLE III – PART A – PROCEDURE FOR REAPPOINTMENTARTICLE III - PART A: PROCEDURE FOR REAPPOINTMENT

### Section 1. Application

1. Each current appointee who is eligible to be reappointed to the Medical Staff shall be responsible for completing the reappointment application form approved by the Board. Instructions for completing reappointment application packages will be e-mailed to the Medical Staff four (4) months prior to expiration of their current appointment period, with a deadline for submission. The reappointment application shall be submitted to the Medical Staff Services Office at least three (3) months prior to the expiration of the appointee's current appointment period. Appropriate checks for annual medical staff dues must accompany the application for the ensuing reappointment period. Any appointee who fails to submit the reappointment application and appropriate dues three (3) months prior to the expiration of the appointee’s current appointment period shall be fined $500.00 to be paid upon submission of their reappointment application and dues. Applicants submitting late reappointment applications will be notified that the failure to submit an application and payment of dues by the deadline may result in automatic expiration of the appointee's appointment and clinical privileges at the end of the then current Medical Staff appointment. Medical Staff members whose appointments have expired because of failure to return reappoint forms and dues will not be eligible to file new applications for appointment to the Staff for three months and will not be entitled to temporary privileges during the time their applications are being processed.
2. Providers with low volume (less than twenty-five (25) patient contacts at Hospital and St. Joseph’s Hospital in the current appointment period, shall be responsible, as part of the reappointment process, for obtaining performance improvement and other relevant information from the other hospitals where they hold active Medical Staff appointments, or office-based practices if they do not currently practice in a hospital setting. Any provider with less than twenty-five (25) patient contacts at Hospital or St. Joseph’s Hospital will be required to submit two peer reference letters. Failure of such staff appointees to provide such information shall render their applications for reappointment incomplete and shall result in the automatic expiration of the appointee's appointment and clinical privileges at the end of the then current Medical Staff year.
3. Reappointment, if granted by the Board, shall be for a period of not more than two years.
4. Reappointment, if granted by the Board, for providers age 70 and older with clinical privileges will be reviewed in the bi-annual cycle as all other providers. These providers will be required to have an annual physical and mental health assessment performed by a physician who is acceptable to the Joint Credentials Committee. This requirement will be monitored as all other expiring items. Failure to submit an annual physical and mental health assessment shall be considered a voluntary relinquishment of clinical privileges until such time as it is received and the privileges are restored.

**ARTICLE III – PART A: PROCEDURE FOR REAPPOINTMENT**

### Section 2. Factors to be Considered

Each recommendation concerning reappointment of an individual currently appointed to the Medical Staff shall be based upon such appointee's:

1. ethical behavior, technical/clinical competence, quality of care, judgment and professional performance in the treatment of patients;
2. attendance at required Medical Staff, departmental, and committee meetings and participation in staff duties;
3. compliance with the bylaws, policies, rules or regulations of the Hospital, its Board and Medical Staff;
4. behavior at the Hospital, including cooperation with Medical Staff and Hospital personnel as it relates to patient care, the orderly operation of the Hospital, and general attitude toward patients, the Hospital and its personnel;
5. use of the Hospital's facilities for patients, taking into consideration the individual's comparative utilization patterns;
6. physical, mental, and emotional health and ability as it relates to performance of privileges requested, including specifically any evidence of current alcohol or drug abuse or dependency;
7. capacity to satisfactorily treat patients as indicated by the results of the Hospital's performance improvement data obtained on a sufficient volume of patients treated in the Hospital(s) and/or other hospitals or office-based practices if they do not currently practice in a hospital setting, to permit an accurate assessment of the quality of care, or other reasonable indicators of continuing qualifications. Any provider with less than twenty-five (25) patients contacts at Candler or St. Joseph’s will be required to submit two peer reference letters;
8. satisfactory completion of a minimum of 40 hours of continuing education requirements per reappointment cycle, which relate, at least in part, to the individual’s clinical privileges, or as may be imposed by law, the Hospital(s), or applicable accreditation agencies; This can be demonstrated by completing the required attestation to include a list of CME’s completed.
9. current professional liability insurance status and pending malpractice challenges, including currently pending claims, suits, judgments and settlements;
10. current licensures, including previously successful or currently pending challenges to any license or registration or any voluntary or involuntary relinquishment of same;
11. voluntary or involuntary termination of Medical Staff appointment or voluntary or involuntary limitation, reduction, or loss of clinical privileges at another hospital; and
12. medical records review, current clinical skills, drug utilization, and other reasonable indicators of continuing qualifications and relevant findings from the Hospital's performance improvement activities.
13. Must maintain Board Certification, or eligibility by the appropriate specialty Board (as defined by MEC policy) [Effective for applicants approved on/after March 1, 2008.]

**ARTICLE III – PART A: PROCEDURE FOR REAPPOINTMENT**

### Section 3. Application for Reappointment

Applications for reappointment shall be reviewed by the Hospital. Those applications which meet the following criteria are deemed complete:

1. Complete information provided on application for reappointment;
2. Copies of current DEA, and professional liability insurance coverage provided;
3. No health problems have been identified;
4. Evidence of appropriate CME provided; and
5. Practitioner-specific profile, Data Bank report, and malpractice data obtained without difficulty, indicating no problematic trends or patterns.

**ARTICLE III – PART A: PROCEDURE FOR REAPPOINTMENT**

### Section 4. Department Chairperson Procedure

1. No later than three months prior to the end of the current appointment period, the President of the Hospital shall send to the chairperson of each department a current list of all appointees who have clinical privileges in that department, together with a description of the clinical privileges each holds, accompanied by copies of their applications. Prior to doing so, however, the President of the Hospital or appropriate designee shall query, and receive a response from, the National Practitioner Data Bank regarding each applicant for reappointment.
2. Within 30 days after receipt of the applications, the department chairperson shall provide the Joint Credentials Committee with a written report concerning each individual seeking reappointment addressing the relevant factors listed in Section 3 of Part A, Article III. The chairperson shall include in each written report, when applicable, the reasons for any changes recommended in staff category, in clinical privileges, or for non-reappointment for those who applied for changes and for those who did not. The chairperson of the department concerned shall be available to the Joint Credentials Committee to answer any questions that may be raised with respect to any such report.
3. Recommendations for increase or decrease of clinical privileges by the department chairperson shall be based upon relevant recent training and upon observation of patient care provided, review of the records of patients treated in a Hospital or any other hospital, and review of all other records of the Medical Staff which evaluate the appointee's participation in the delivery of medical care.

**ARTICLE III – PART A: PROCEDURE FOR REAPPOINTMENT**

### Section 5. Joint Credentials Committee Procedure

1. Within thirty (30) days after receiving the reports from each department chairperson or his/her designee, the Joint Credentials Committee shall review all pertinent information available, including all information provided from other committees of either or both Medical Staffs and from Hospital management, for the purpose of determining its recommendations for staff reappointment, for change in staff category, and for the granting of clinical privileges for the ensuing appointment period. The Chairman of the Joint Credentials Committee is empowered to review the application and make a recommendation. His actions shall be reported at the next meeting of the Joint Credentials Committee.
2. As part of the process of making its recommendation, the Joint Credentials Committee may require that an individual currently seeking reappointment procure a physical and/or mental examination by a physician or physicians satisfactory to the Joint Credentials Committee either as part of the reapplication process or during the appointment period to aid it in determining whether clinical privileges should be granted or continued. The results of such examination shall be available for the Joint Credentials Committee's consideration. Failure of an individual seeking reappointment to procure such an examination within a reasonable time after being requested to do so in writing by the Joint Credentials Committee shall constitute a voluntary relinquishment of all clinical privileges until such time as the Joint Credentials Committee has received the examination results and has had a reasonable opportunity to evaluate them and make a recommendation thereon.
3. The Joint Credentials Committee shall have the right to require the appointee to meet with the committee to discuss any aspect of the individual's reappointment application, qualifications, or clinical privileges requested.
4. The Joint Credentials Committee may use the expertise of the department chairperson, or any member of the department, or an outside consultant, if additional research is required into the appointee's qualifications for reappointment.
5. If, after considering the report of the clinical department chairperson concerned, the Joint Credentials Committee's recommendation is favorable, it shall recommend reappointment and the specific clinical privileges to be granted, which may be qualified by any probationary or other conditions or restrictions, as appropriate.

**ARTICLE III – PART A: PROCEDURE FOR REAPPOINTMENT**

### Section 6. Favorable Joint Credentials Committee Recommendation and MEC Review and Comment

1. If the Joint Credentials Committee or its designee’s recommendation is to reappoint the individual and to grant the requested clinical privileges, it shall send this recommendation and written findings in support thereof to the MEC of each Hospital where staff reappointment and/or clinical privileges are requested. After reviewing the Joint Credentials Committee or its designee’s recommendation, the MEC(s) may (1) accept the Joint Credentials Committee's report and adopt it as its own, (2) send any recommendation of the Joint Credentials Committee back to that committee for further review, or (3) recommend against approval of the recommendation of the Joint Credentials Committee. Each MEC shall forward its review and recommendation to the Board, including the findings and recommendations of the Joint Credentials Committee. The subcommittee reports its actions to the Board at the next regular meeting.
2. Applications meeting the following criteria must be forwarded to the full Board of each hospital where application is being made and privileges are requested:
3. The applicant submitted an incomplete application;
4. There is a current challenge or previously successful challenge to licensure or registration;
5. The applicant has received an involuntary termination of medical staff membership at another organization;
6. The applicant has received involuntary limitation, reduction, denial, or loss of clinical privileges;
7. There has been a new final judgment adverse to the applicant in a professional liability action that has not previously been reviewed or considered;
8. A pattern of liability claims is identified; or
9. The MEC made a final recommendation that is adverse or with limitations.
10. Upon receipt of a favorable recommendation from the Joint Credentials Committee or its designee and favorable review and comment from its MEC that the individual be granted reappointment and the requested clinical privileges, the Board or its subcommittee consisting of at least two Board members, may:
11. reappoint the individual and grant clinical privileges as recommended; or
12. refer the matter to either committee or to another source inside or outside the Hospital for additional research or information; or
13. reject the recommendation.
14. If the Board determines to reject the favorable recommendation of the Joint Credentials Committee and favorable review and comments of the MEC, it should first discuss the matter with the Chairperson(s) of those committees, or it may refer the matter back to either committee for further research, investigation and recommendation or to another source inside or outside the Hospital. If the Board's determination remains unfavorable to the individual, the President of the Hospital shall promptly notify the individual of that determination with the reasons therefor, in writing, certified mail, return receipt requested. The Board shall make no final decision until the individual has had an opportunity to exercise the right to a hearing and appeal as provided in these Bylaws.

**ARTICLE III – PART A: PROCEDURE FOR REAPPOINTMENT**

### Section 7. Unfavorable Joint Credentials Committee Recommendation

If the Joint Credentials Committee's recommendation is unfavorable, is ratified by the MEC, and would entitle the individual to request a hearing pursuant to these Bylaws, it shall be forwarded to the President of the Hospital who shall promptly so notify the individual in writing, certified mail, return receipt requested. The individual shall then have an opportunity to exercise the right to a hearing and appeal as provided in these Bylaws.

**ARTICLE III – PART A: PROCEDURE FOR REAPPOINTMENT**

### Section 8. Favorable Joint Credentials Committee Recommendation, but Unfavorable MEC Review and Comments

If the Joint Credentials Committee's recommendation is to reappoint the individual and to grant the requested clinical privileges, but a MEC's comments are unfavorable and would entitle the appointee to request a hearing pursuant to these Bylaws, the MEC shall set forth in its comments clear and convincing reasons, along with supporting information, for its changes and forward its comments together with the Joint Credentials Committee's findings and recommendation to the Board. Thereafter, the Board or the President of the Hospital shall meet with the Chairpersons of the Joint Credentials and MECs to see if the disagreement can be resolved. After that meeting:

1. If the Board, after informal discussion, is inclined to take action that would entitle the appointee to request a hearing pursuant to these Bylaws, it shall inform the President of the Hospital who shall promptly so notify the appointee in writing, return receipt requested, and make no decision until the appointee has had an opportunity to exercise the right to a hearing and appeal as provided in these Bylaws;
2. If the Board determines to reappoint the applicant and grant requested clinical privileges, that decision shall be final;
3. If the Board wishes further study to resolve the difference in recommendation by the Joint Credentials Committee and the findings by the MEC, it may refer the application for reappointment to either committee for further research, investigation and recommendation or to another source inside or outside the hospital. Upon receipt of such further information, the Board shall proceed as outlined in (a) or (b) of this subpart.

**ARTICLE III – PART A: PROCEDURE FOR REAPPOINTMENT**

### Section 9. Meeting with Affected Individual

If, during the processing of a particular individual's application for reappointment, it becomes apparent to the Joint Credentials Committee or its Chairperson that the committee is considering a recommendation that would deny reappointment, deny a requested change in staff category or clinical privileges, or reduce clinical privileges, the Chairperson of the Joint Credentials Committee may notify the individual of the general tenor of the possible recommendation and ask if the individual desires to meet with the committee prior to any final recommendation by the committee. At such meeting, the affected individual shall be informed of the general nature of the evidence supporting the action contemplated and shall be invited to discuss, explain, or refute it. This interview shall not constitute a hearing and none of the procedural rules provided in these Bylaws with respect to hearings shall apply nor shall minutes of the discussion in the meeting be kept. However, the committee shall indicate as part of its report to the MEC and the Board whether such a meeting occurred.

## ARTICLE III – PART B: PROCEDURES FOR REQUESTING INCREASE IN CLINICAL PRIVILEGES

### Section 1. Application for Increased Clinical Privileges

Whenever, during the term of appointment to a Medical Staff, increased clinical privileges are desired, the appointee requesting increased privileges shall apply in writing to the President of the Hospital. The application shall state in detail the specific additional clinical privileges desired and the appointee's relevant recent training and experience which justify increased privileges. This application shall be transmitted by the President of the Hospital to the appropriate department chairperson(s). Thereafter, it will be processed in the same manner as an application for initial clinical privileges if the request is made during the term of appointment, or as a part of the reappointment application if the request is made at that time.

**ARTICLE III – PART B: PROCEDURES FOR REQUESTING INCREASE IN CLINICAL PRIVILEGES**

### Section 2. Factors to be Considered

Recommendations for an increase in clinical privileges made to the Board shall be based upon:

1. relevant recent training;
2. observation of patient care provided;
3. review of a sufficient volume of procedures performed in this or other hospitals to demonstrate the physician's competence in providing quality care;
4. results of the Hospital's performance improvement activities; and
5. other reasonable indicators of the individual's continuing qualifications for the privileges in question to include evaluation of quality assurance data.

## PROCEDURE FOR OTHER QUESTIONS INVOLVING MEDICAL STAFF APPOINTEES

## SeARTICLE III – PART C: PROCEDURE FOR OTHER QUESTIONS INVOLVING MEDICAL STAFF APPOINTEES

### Section 1. Grounds for Action

Whenever, on the basis of information and belief, the President of the Medical Staff, the chairperson of a clinical department, the chairperson or a majority of any Medical Staff committee, the Chairperson of the Board, or the President of the Hospital has cause to question:

1. the clinical competence of any Medical Staff appointee;
2. the care or treatment of a patient or patients or management of a case by any Medical Staff appointee;
3. the known or suspected violation by any Medical Staff appointee of applicable ethical standards or the bylaws, policies, rules or regulations of the Hospital, the Board or Medical Staff, including, but not limited to the Hospital's performance improvement, risk management, and utilization review programs; or
4. behavior or conduct on the part of any Medical Staff appointee that is considered lower than the standards of the Hospital or disruptive to the orderly operation of the Hospital or its Medical Staff, including the inability of the appointee to work harmoniously with others;

a written request for an investigation of the matter shall be addressed to the Joint Credentials Committee making specific reference to the activity or conduct that gave rise to the request. The Chairperson of the Joint Credentials Committee shall promptly notify the MEC in writing of all such requests and investigations and shall keep the President of the Hospital and MEC fully informed of all action taken in connection therewith.

**ARTICLE III – PART C: PROCEDURE FOR OTHER QUESTIONS INVOLVING MEDICAL STAFF APPOINTEES**

### Section 2. Investigative Procedure

The Joint Credentials Committee shall meet within seven (7) days after receiving the request for an investigation:

1. if the request for an investigation contains sufficient information to warrant a recommendation, the Joint Credentials Committee, at its discretion, shall make such a recommendation, and may do so with or without a personal interview with the individual being investigated. However, the individual being investigated shall be notified of the general nature of such investigation at this time;
2. if the request for an investigation does not contain sufficient information to warrant a recommendation, the Joint Credentials Committee shall immediately investigate the matter, appoint a subcommittee to do so, or appoint an ad hoc investigating committee consisting of up to three persons, who may or may not hold appointments to the Medical Staff. This committee shall not include partners, associates, or relatives of the individual being investigated;
3. the Joint Credentials Committee, its subcommittee, or the ad hoc investigating committee shall have available to it the full resources of the Medical Staff(s) and the Hospital(s) where the appointee holds staff membership and/or clinical privileges, as well as the authority to use outside consultants, if needed. The committee may also require a physical and mental examination of the individual being investigated, by a physician or physicians satisfactory to the committee, and shall require that any pertinent results of such examination be made available for the committee's consideration;
4. the individual being investigated shall have an opportunity to meet with the investigating committee before it makes its report. At this meeting (but not, as a matter of right, in advance of it) the individual shall be informed of the general nature of the evidence supporting the question being investigated and shall be invited to discuss, explain, or refute it. This interview shall not constitute a hearing, and none of the procedural rules provided in these Bylaws with respect to hearings shall apply. A summary of such interview shall be made by the investigating committee and included with its report to the Joint Credentials Committee; and
5. if a subcommittee or ad hoc investigating committee is used, the Joint Credentials Committee may accept, modify, or reject the recommendation it receives from that committee.

**ARTICLE III – PART C: PROCEDURE FOR OTHER QUESTIONS INVOLVING MEDICAL STAFF APPOINTEES**

### Section 3. Precautionary Suspension of Privileges

1. At any time during the investigation, the Joint Credentials Committee, with the approval of the President of the Hospital, may suspend all or any part of the clinical privileges of the individual being investigated, in accordance with Section 1 of Part D, Article III. This suspension shall be deemed to be administrative in nature, for the protection of Hospital patients. It shall remain in effect during the investigation only, shall not indicate the validity of the charges, and shall remain in force, without appeal, during the course of the investigation. If such a suspension is placed into effect, the investigation shall be completed expeditiously or reasons for the delay shall be transmitted to the Board so that it may consider whether the precautionary suspension should be lifted. Such precautionary suspension shall be deemed an interim precautionary step in the professional review activity related to the ultimate professional review action that will be taken with respect to the suspended individual but is not a complete professional review action in and of itself. It shall not imply any final finding of responsibility for the situation that caused the suspension.
2. In the event of suspension of privileges, the appropriate department chairperson, or if unavailable, the President of the Medical Staff, shall immediately assign to another staff appointee with appropriate clinical privileges responsibility for the care of the patients of the suspended appointee until the suspension has been lifted or such patients are discharged from the Hospital, giving consideration wherever possible to the wishes of the patient in the selection of the assigned appointee.

**ARTICLE III – PART C: PROCEDURE FOR OTHER QUESTIONS INVOLVING MEDICAL STAFF APPOINTEES**

### Section 4. Procedure Thereafter

1. In acting after the investigation, the Joint Credentials Committee may recommend the following to the MEC:
2. no action is justified;
3. written warning;
4. letter of reprimand;
5. terms of probation;
6. a requirement for consultation;
7. reduction of clinical privileges;
8. suspension of clinical privileges for a term;
9. revocation of staff appointment; or
10. such other recommendations as it deems necessary or appropriate. After reviewing the Joint Credentials Committee’s recommendation, the MEC may (1) accept the Joint Credentials Committee's recommendation and adopt it as its own, (2) send any recommendation of the Joint Credentials Committee back to that committee for further review, or (3) recommend against approval of the recommendation of the Joint Credentials Committee.
11. Any recommendation by the MEC that would entitle the individual being investigated to the procedural rights provided in these Bylaws shall be forwarded to the President of the Hospital who shall promptly notify the affected individual by certified mail, return receipt requested. The President of the Hospital shall then hold the recommendation until after the individual has exercised or has been deemed to have waived the right to a hearing.
12. The MEC shall forward its recommendation to the Board and the Chairperson of the MEC shall be available to the Board to answer any questions that may be raised with respect to the recommendation.
13. If the action of the MEC does not entitle the individual to a hearing, it shall take effect immediately without action of the Board and without the right of appeal to the Board. A report of the action taken and reasons therefor shall be made to the Board through the President of the Hospital and the action shall stand unless modified by the Board.
14. In the event the Board determines to modify the MEC's recommendation, and such modification would entitle the individual to a hearing in accordance with these Bylaws, the affected individual shall be notified by the President of the Hospital, and the Board shall take no final action thereon until the individual has had an opportunity to exercise the right to a hearing and appeal as provided in these Bylaws.

## ARTICLE III – PART D: SUMMARY OF SUSPENSION OF CLINICAL PRIVILEGES

## ARTICLE III - PART D: SUMMARY SUSPENSION OF CLINICAL PRIVILEGES

### Section 1. Grounds for Summary Suspension

1. The President of a Medical Staff, the Chairperson of a clinical department, or the Chairperson of the Joint Credentials Committee, in conjunction with the President of the Hospital, Vice President of Medical Affairs, or the Administrator on Call shall have the authority to summarily suspend all or any portion of the clinical privileges of a Medical Staff appointee or other individual whenever failure to take such action may result in an imminent danger to the health and/or safety of any individual. Such summary suspension shall be deemed an interim precautionary step in the professional review activity related to the ultimate professional review action that will be taken with respect to the suspended individual but is not a complete professional review action in and of itself. It shall not imply any final finding of responsibility for the situation that caused the suspension.
2. A summary suspension shall become effective immediately upon imposition, shall immediately be reported in writing to the President of the Hospital, the President of the affected Medical Staff(s), and the Chairperson of the Joint Credentials Committee, and shall remain in effect unless or until modified by the President of the Hospital or the Board. The summary suspension shall be deemed an interim precautionary step in the professional review activity related to the ultimate professional review action that will be taken with respect to the suspended individual but is not a complete professional review action in and of itself.

**ARTICLE III – PART D: SUMMARY SUSPENSION OF CLINICAL PRIVILEGES**

### Section 2. Joint Credentials Committee Procedure

1. Any individual who exercises authority under Section 1 of this Part to summarily suspend clinical privileges as a precaution shall immediately report this action to the Chairperson of the Joint Credentials Committee to take further action in the matter.
2. A review of the matter resulting in summary suspension shall be completed within a reasonable time period not to exceed fourteen (14) days or reasons for the delay shall be transmitted to the Board so that it may consider whether the suspension should be lifted. In the event the suspension is lifted, the Joint Credentials Committee shall take such further action as is required in the manner specified under Part C of this Article III. The summary suspension shall remain in force after the appropriate committee takes responsibility unless and until modified by that committee or the President of the Hospital, or until the matter that required the suspension is finally resolved.

**ARTICLE III – PART D: SUMMARY SUSPENSION OF CLINICAL PRIVILEGES**

### Section 3. Care of Suspended Individual's Patients

1. Immediately upon the imposition of a precautionary suspension, the appropriate department chairperson or, if unavailable, the President of the appropriate Medical Staff(s), shall assign to another individual with appropriate clinical privileges responsibility for care of the suspended individual's patients still in the hospital at the time of such suspension until such time as they are discharged. The wishes of the patient shall be considered in the selection of the assigned appointee.
2. It shall be the duty of all medical and dental staff appointees to cooperate with the President of the Hospital in enforcing all suspensions.

## ARTICLE III – PART E: OTHER ACTIONS

### Section 1. Failure to Complete Medical Records

The Medical Records Committee(s) shall notify any member of its staff who fails to complete his/her records within thirty (30) days after a patient's discharge that he/she will automatically relinquish all privileges until he/she is in compliance (unless the Medical Records Committee determines that the staff appointee is without fault). The individual physician may continue to care for any patients currently in house until they are discharged. Such relinquishment shall continue until all the records of the individual's patients are no longer delinquent. Timely completion of specific medical record documents, i.e., history and physical, procedure and operative reports, etc., will be as specified in the Rules and Regulations of the Medical Staff and any applicable laws and regulations. Failure to complete the medical records that caused relinquishment of clinical privileges after six months from the relinquishment of clinical privileges shall constitute a voluntary relinquishment of all clinical privileges and resignation from the Medical Staff.

**ARTICLE III – PART E: OTHER ACTIONS**

### Section 2. Action by State Licensing Agency

Action by the appropriate state licensing board or agency revoking or suspending an individual's professional license, or loss or lapse of state license to practice for any reason, shall result in voluntary relinquishment of Medical Staff membership and all Hospital clinical privileges as of that date. The individual may reapply for staff membership and clinical privileges when the license has been fully reinstated. In the event the individual's license is only partially restricted, the clinical privileges that would be affected by the license restriction shall be similarly voluntarily restricted and the Joint Credentials Committee shall investigate the cause for the state action and, if appropriate, shall recommend any monitoring or modification of privileges indicated by the investigation. It is the responsibility of the Medical Staff Member to report any and all adverse actions taken by any State Licensing Agency to the Joint Credentials Committee*.*

**ARTICLE III – PART E: OTHER ACTIONS**

### Section 3. Failure to be Adequately Insured

If at any time an appointee's professional liability insurance coverage lapses, falls below the required minimum, is terminated or otherwise ceases to be in effect (in whole or in part), the appointee's clinical privileges that would be affected shall be voluntarily relinquished or restricted as applicable as of that date until the matter is resolved and adequate professional liability insurance coverage is restored.

**ARTICLE III – PART E: OTHER ACTIONS**

### Section 4. Failure to Satisfy Continuing Education Requirements

1. Failure to complete mandated continuing education requirements shall be sufficient grounds for refusing to reappoint the individual concerned. Such failures shall be documented and specifically considered by the Joint Credentials Committee and the MEC when making recommendations for reappointment and by the Board when making its final decisions.
2. Any appointee whose reappointment has been refused for failure to satisfy continuing education requirements shall be entitled to meet with a committee to be designated by the Board before final action is taken. This meeting with the Board committee shall not be conducted under the procedural rules provided in these Bylaws.
3. If reappointment is refused by the Board, the individual shall be eligible to reapply for staff appointment after six months, and the application shall be processed in the same manner as if it were an initial application.

**ARTICLE III – PART E: OTHER ACTIONS**

### Section 5. Exclusion from Federally Funded Healthcare Programs

Exclusion of a Medical Staff Member by the Federal or a State government from participating in Medicare, Medicaid and other Federal non-procurement programs based on the authority contained in Sections 1128 and 1156 of the Social Security Act, shall result in voluntary relinquishment of Medical Staff membership and all Hospital clinical privileges as of that date. The individual may reapply for staff membership and clinical privileges when the ability to participate in such programs has been fully reinstated. It is the responsibility of the Medical Staff Member to report any and all adverse actions taken by any Federally Funded Healthcare Programs to the Joint Credentials Committee.

**ARTICLE III – PART E: OTHER ACTIONS**

### Section 6. Providers over the age of 70 with clinical privileges

1. Providers age seventy (70) and older with clinical privileges will be reviewed for reappointment in the bi-annual cycle as with all other providers. It is the policy of the Medical Staff that the capabilities, competencies and health status (ability to perform) of each practitioner who has privileges and is age seventy (70) and older be assessed annually in accordance with these Bylaws and policies and procedures of the Medical Staff related to clinical privileging. Providers age seventy (70) and older and holding clinical privileges shall complete an examination that addresses both the physical and mental capacity for the privileges requested. The annual physical and mental health assessment will be performed by a primary care physician who is acceptable to the Joint Credentials Committee and documented on the approved form and submitted by the requested date. A copy of the practitioner’s privileges requested are to be sent to the examining physician along with the required reporting form (Form Available from Medical Staff Services).
2. The results of the examination will be reviewed by the Department Chairperson, Chairperson(s) of the Joint Credentials Committee and /or President of the Medical Staff. If findings do not identify potential concerns with the physician’s capabilities, competency or ability to perform privileges requested, the results will be filed in a confidential file as a matter of routine. If in the opinion of the Department Chairperson, Chairperson of the Joint Credentials Committee and/or President of the Medical Staff the results are of concern, the information will be shared with the Joint Credentials Committee who will be responsible for making recommendations as to additional examination and/or limiting of privileges.
3. This requirement will be monitored as all other expiring items. Failure to submit an annual physical and mental health assessment, within 90 days of the requested time and on the required form shall be considered voluntary relinquishment of clinical privileges until such time as it is received and the privileges are restored.

**ARTICLE III – PART E: OTHER ACTIONS**

### Section 7. Procedure for Voluntary Leave of Absence

1. Individuals appointed to the Medical Staff may, for good cause stated in writing, be granted leaves of absence by the Board for a stated period of time not to exceed one (1) year. Absence for longer than one (1) year shall constitute voluntary resignation of Medical Staff appointment and clinical privileges, unless an exception is made by the Board.
2. Requests for leaves of absence shall be made to the chairperson of the department in which the individual applying for leave holds clinical privileges, and shall state the beginning and ending dates of the requested leave and identify the covering physician(s), if any. The department chairperson shall transmit the request together with a recommendation to the President of the Hospital for action by the Board.
3. At the conclusion of the leave of absence, the individual may be reinstated, upon filing a written statement with the President of the Hospital summarizing the professional activities undertaken during the leave of absence. The individual shall also provide such other information as may be requested by the Hospital at that time.
4. In acting upon the request for reinstatement, the Board may approve reinstatement either to the same or a different staff category, and may limit or modify the clinical privileges to be extended to the individual upon reinstatement.

**ARTICLE III – PART E: OTHER ACTIONS**

### Section 8. Procedures for the Impaired Staff Member

1. Application. The actions and procedures provided for herein are in addition to the provisions previously set out in this Article III.
2. Policy. It shall be the policy of the Hospital, through their respective Medical Staff to provide certain procedures and mechanisms for the identification, intervention and referral for treatment of members of the Medical Staff who are identified as being impaired as hereinafter defined.
3. Definition. For purposes of this section "impaired" shall mean (i) excessive use or abuse of any narcotic drug or chemical, including alcohol, or (ii) inability to practice medicine with reasonable skill and safety to patients because of physical or mental illness, including loss of motor skills or deterioration through aging.
4. Procedures.
5. Any staff member who is considered to be impaired by a member of a Medical Staff shall be reported immediately to the relevant department chairperson. If the department chairperson is not available, the report shall be made to the President of the Medical Staff or his/her designee. If the staff member is reported by individuals other than the Medical Staff, the report shall be directed to the President of the Hospital.
6. Upon receiving a report and subjective description of a staff member considered impaired, the department chairperson, or designee, shall review the relevant facts, including a discussion of the incident with the individual who filed the report and personal observation of a meeting with the impaired staff member.
7. The President of the Medical Staff or designee, and one of the following -- Chairperson of the department, Chairperson of the Joint Credentials Committee, or President of the Hospital -- shall have the authority whenever action is deemed necessary in the best interest of patient care in a Hospital, to summarily suspend all or any portion of the clinical privileges of an impaired staff member, and to make arrangements for transfer of the staff member's admitted patients to another staff member's service. Each summary suspension shall become effective immediately upon imposition.
8. Within five (5) working days the suspension or limitation of the impaired staff member's privileges shall be reviewed by the Joint Credentials Committee. If the Joint Credentials Committee deems it necessary to modify, limit or withdraw the privileges of the impaired staff member, this recommendation will be forwarded to the MEC for immediate action pursuant to Part C, Article III of these Bylaws. An impaired staff member whose privileges have been suspended or limited may request an ad hoc hearing in accordance with Article V of these Bylaws.

(e) Report to Composite State Board of Medical Examiners.

Disciplinary action taken against an impaired staff member which results in privileges being denied, restricted or revoked for any reason involving the medical care of patients shall be reported to the Composite State Board of Medical Examiners, in accordance with Section 37-7-8 of the Official Code of Georgia.

(f) Reinstatement of Privileges of an Impaired Staff Member.

At its discretion, the Joint Credentials Committee may require any or all of the following agreements or undertakings by an impaired staff member before recommending reinstatement of such staff member's privileges:

1. Active participation in an ongoing after-care program in which the Hospital and Medical Staff have confidence which will provide ongoing support services to the impaired staff member. The staff member must agree to continue in the program and to abide by the terms of the program. The program must remain in place for at least 24 months, and be reviewed by the Joint Credentials Committee at four month intervals.
2. A letter to the Chairperson of the Joint Credentials Committee from the treatment center providing care to the impaired staff member, which covers a description of the impairment, its current status, a description of the treatment, and a statement of the long-term prognosis.
3. A letter from the impaired staff member's primary care physician to the Chairperson of the Joint Credentials Committee, covering the points listed in subsection (2) above and the primary care physician's opinion of whether the impairment has been corrected.
4. The impaired staff member's agreement to comply with any recommendations of any drug enforcement license agency, addressed to the Chairperson of the Joint Credentials Committee.
5. The impaired staff member's agreement to offer and obtain supervised urine/blood samples for drug screens at the discretion of the impaired health professional program, after-care coordinator or the impaired staff member's primary care physician. A report of this screen should be available to the Chairperson of the Joint Credentials Committee.
6. Agreement by the impaired staff member to abstain completely from any mood-changing chemical, except as prescribed by his/her primary care physician.
7. In the event of any relapse, agreement by the impaired staff member and his/her primary care physician to notify the President of the Medical Staff and/or the Chairperson of the Joint Credentials Committee.
8. The impaired staff member's agreement to attend regularly a self-help group (e.g., AA/NA) and supply the Chairperson of the Joint Credentials Committee with its name, location, time of meetings, and contact person.
9. The impaired staff member's agreement to any special terms concerning his or her disease as outlined by the Joint Credentials Committee.
10. Failure by the impaired staff member to adhere to the above conditions will result in automatic suspension by the President of the Medical Staff(s) or designee(s).
11. Reappointment to the Medical Staff shall be reviewed on an annual basis for a period of at least five years.

**ARTICLE III – PART E: OTHER ACTIONS**

### Section 9. Failure to Satisfy Immunization, Health Eligibility, and Health Screening Requirements

1. Failure to satisfy all immunization, health eligibility and health screening requirements, including the immunization, health eligibility and health screening requirements of hospital (e.g. COVID 19 vaccine, Tuberculin skin testing, chest x-ray, and/or Tuberculin signs and symptoms screen or annual physical and mental health assessment,) shall constitute voluntary relinquishment of privileges until such time as all such requirements are met and documentation is received in the Medical Staff Services office.
2. The physician shall be responsible for obtaining coverage for any patients in the hospital and for any emergency unassigned call.
3. Failure to complete the required immunization, health eligibility and/or health screening requirements that constitute(d) voluntary relinquishment of clinical privileges after six months from said relinquishment of clinical privileges shall constitute a voluntary relinquishment of all clinical privileges and resignation from the Medical Staff.

## ARTICLE III – PART F: CONFIDENTIALITY AND REPORTING

Actions taken and recommendations made pursuant to this Article III shall be treated as confidential in accordance with such policies regarding confidentiality as may be adopted by the Board. In addition, reports of actions taken pursuant to these Bylaws shall be made by the President of the Hospital to such governmental agencies as may be required by law.

## ARTICLE III – PART G: PEER REVIEW PROTECTION

All minutes, reports, recommendations, communications, and actions made or taken pursuant to these Bylaws are deemed to be covered by the provisions of Ga. Code Ann. Section 31-7-130 to 31-7-133 and Section 31-7-140 to 31-7-143 and the corresponding provisions of any subsequent federal or state statute providing protection to peer review or related activities. Furthermore, the committees and/or panels charged with making reports, findings, recommendations or investigations pursuant to these Bylaws shall be considered to be acting on behalf of the Hospital and the Board when engaged in such professional review activities and thus shall be deemed to be "professional review bodies" as that term is defined in the Health Care Quality Improvement Act of 1986.

# ARTICLE IVCATEGORIES OF THE MEDICAL STAFF

All Staff shall be assigned to a specific department, but shall be eligible for clinical privileges in other departments as applied for and recommended pursuant to these Bylaws.

## ARTICLE IV – PART A: ACTIVE STAFF

### Section 1. Qualifications

The Active Staff shall consist of those physicians, dentists, podiatrists, and psychologists who:

1. are active in Medical Staff activities and responsibilities, such as committee and department assignments;
2. regularly attend, admit, or are involved in the treatment of ten (10) or more patients at the Hospital annually.

Active Staff members shall be located within the geographic service area of the Hospital as defined by the Board, close enough to fulfill their responsibilities and to provide timely and continuous care for their patients in the Hospital.

**ARTICLE IV – PART A: ACTIVE STAFF**

### Section 2. Responsibilities

Each member of the Active Staff, by accepting appointment, shall agree to:

1. assume the functions and responsibilities of appointment to the Active Staff, including, where appropriate, care for unassigned patients and, emergency service care when assigned by the department chair, consultation and teaching assignments;
2. attend Medical Staff and department meetings when required;
3. serve on Medical Staff committees;
4. faithfully perform the duties of any office or position to which elected or appointed;
5. participate in performance improvement activities, including the evaluation of medical staff members, as assigned by department or committee chairpersons; and
6. pay all staff dues and assessments when due.

**ARTICLE IV – PART A: ACTIVE STAFF**

### Section 3. Prerogatives

Active Staff members are:

1. entitled to vote, hold office, serve on Medical Staff committees, and serve as chairpersons of such committees; and
2. entitled to admit and treat patients within the limits of their assigned clinical privileges.

## ARTICLE IV – PART B: ASSOCIATE STAFF

### Section 1. Qualifications

The Associate Staff shall consist of physicians, dentists, podiatrists and psychologists of demonstrated competence qualified for staff appointment, who:

1. are not eligible for appointment to the Active Staff because, during each appointment year, they attend, admit, or are involved in the care of less than ten (10) patients per year at the Hospital (this shall not include use of the Hospital's diagnostic facilities, access to which is unlimited, nor shall it include the medical specialties of Pathology, Dermatology and any other specialty or individual with primarily an office-based practice who request and are exempted from minimum patient contacts by vote of the Credentials Committee with approval of the MEC and the Board);
2. are located within the geographic service area of the Hospital as defined by the Board, close enough to fulfill their responsibilities and to provide timely and continuous care for their patients in the Hospital;
3. at each reappointment time, provide evidence of clinical performance in such form as may be required by the department, Credentials Committee, MEC, or Board in order to allow for an appropriate assessment of continued qualifications for Medical Staff appointment and clinical privileges.

**ARTICLE IV – PART B: ASSOCIATE STAFF**

### Section 2. Responsibilities

Each appointee to the Associate Staff shall:

1. be encouraged but not required to attend Staff meetings, but may be required to attend meetings pursuant to Section 2 of Part E, Article VII;
2. assume all functions and responsibilities as assigned including, where appropriate, consultation and teaching assignments;
3. serve on Medical Staff Committees (but not hold office); and
4. pay all Staff dues and assessments when due.

**ARTICLE IV – PART B: ASSOCIATE STAFF**

### Section 3. Prerogatives

Associate Staff members:

1. may serve and vote on Staff committees but may not hold office or vote on department or Staff issues;
2. may accept emergency service care when assigned by the department chair;
3. are entitled to admit and treat patients (pursuant to Section 1) within the limits of their assigned clinical privileges; and
4. are permitted to use the Hospital's diagnostic facilities without limitation.

## ARTICLE IV – PART C: EMERITUS RECOGNITION

### Section 1. Qualifications

Appointment to the Emeritus Staff is limited to former Active Staff members who have retired but wish to remain eligible to attend continuing education, social and other such activities in the Hospital.

**ARTICLE IV – PART C: EMERITUS RECOGNITION**

### Section 2. Responsibilities and Prerogatives

Persons appointed to the Emeritus Staff shall not be eligible to admit or to attend patients, to vote, to hold office, or to serve on standing Medical Staff committees, but may, for good cause, be appointed to serve and vote on special or standing committees. They may, but are not required to attend any Medical Staff meetings. Emeritus Staff members are not required to pay dues.

# ARTICLE VHEARING AND APPEAL PROCEDURES

## ARTICLE V – PART A: INITIATION OF HEARING

## ARTICLE IV - PART A: INITIATION OF HEARING

### Section 1. Grounds for Hearing

1. An applicant or an individual holding a Medical Staff appointment as a physician, dentist, podiatrist or psychologist at Hospital shall be entitled to request a hearing whenever an unfavorable recommendation which pertains to clinical competence or professional conduct has been made by the Joint Credentials Committee or a Board regarding the following:
2. denial of initial Medical Staff appointment;
3. denial of requested advancement in Medical Staff category, when said action affects the exercise of privileges;
4. denial of Medical Staff reappointment;
5. revocation of Medical Staff appointment;
6. denial of requested initial clinical privileges;
7. denial of requested increased clinical privileges;
8. decrease of clinical privileges;
9. suspension of clinical privileges, but only if such suspension is for more than 14 calendar days; or
10. imposition of mandatory concurring consultation requirement, but only if such mandatory concurring consultation is applied for more than fourteen calendar days
11. No other recommendations except those enumerated in (a) of this section shall entitle the individual to request a hearing.
12. The affected individual shall also be entitled to request a hearing before the Board enters a final decision, in the event the Board should determine, without a similar recommendation from the Joint Credentials Committee, to take any action set forth above.
13. The hearing shall be conducted in as informal a manner as possible, subject to the rules and procedures set forth in these Bylaws.
14. Neither voluntary relinquishment of clinical privileges, as provided for elsewhere in these Bylaws, nor the imposition of any general consultation requirement, nor the imposition of a requirement for retraining, additional training, or continuing education, shall constitute grounds for a hearing, but shall take effect without hearing or appeal.
15. If the grounds for the hearing involve an individual's staff membership and/or clinical privileges at Hospital and St. Joseph’s Hospital, all of the procedures set forth in this Article V for hearings and appeals except final Board action may be taken jointly by Hospital and St. Joseph’s Hospital.

**ARTICLE V – PART A: INITIATION OF HEARING**

## ARTICLE IV - PART B: THE HEARING

### Section 2. Notice of Recommendation

When a recommendation is made which, according to these Bylaws entitles an individual to a hearing prior to a final decision of the Board, the affected individual shall promptly be given notice by the President of the Hospital, in writing, certified mail, return receipt requested. This notice shall contain:

1. a statement of the recommendation made and the general reasons for it;
2. notice that the individual has the right to request a hearing on the recommendation within 30 days of receipt of this notice; and
3. a copy of this Article V outlining the rights in the hearing as provided for in these Bylaws.

## ARTICLE V – PART B: THE HEARING

### Section 1. Request for Hearing

Such individual shall have 30 days following the date of the receipt of such notice within which to request the hearing. Said request shall be made by written notice sent by certified mail, return receipt requested, to the President of the Hospital. In the event the affected individual does not request a hearing within the time and in the manner hereinabove set forth, that individual shall be deemed to have waived the right to such hearing and to have accepted the action involved, and such action shall thereupon become effective immediately upon final Board action.

**ARTICLE V – PART B: THE HEARING**

### Section 2. Notice of Hearing and Statement of Reasons

1. The President of the Hospital shall schedule the hearing and shall give written notice, certified mail, return receipt requested, to the person who requested the hearing. The notice shall include:
2. the time, place, and date of the hearing;
3. a proposed list of witnesses who will give testimony or evidence in support of the Joint Credentials Committee or the Board at the hearing;
4. the names of the Hearing Panel members/Hearing Officer, if known; and
5. a statement of the specific reasons for the recommendation, as well as the list of patient records and information supporting the recommendation. This statement, and the list of supporting patient record numbers and other information it contains, may be amended or added to at any time, even during the hearing so long as the additional material is relevant to the appointment or clinical privileges of the individual requesting the hearing, and that individual and the individual's counsel have sufficient time to study this additional information and rebut it.
6. The hearing shall begin as soon as practicable, but no sooner than 30 days after the notice of the hearing unless an earlier hearing date has been specifically agreed to in writing by the parties.

**ARTICLE V – PART B: THE HEARING**

### Section 3. Witness List

The individual requesting the hearing shall provide a written list of the names and addresses of the individuals expected to offer testimony or evidence on the affected individual's behalf within 10 days after receiving notice of the hearing. Each witness list shall include a brief summary of the nature of the anticipated testimony. The witness list of either party may, in the discretion of the Presiding Officer, be supplemented or amended at any time during the course of the hearing, provided that notice of the change is given to the other party. The Presiding Officer shall have the authority to limit the number of witnesses as set forth in Section 5 below.

**ARTICLE V – PART B: THE HEARING**

### Section 4. Hearing Panel and Presiding Officer

1. Hearing Panel:
2. When a hearing is requested, the President of the Hospital, acting with the President of the Medical Staff (and the Chairperson of the Board, if the hearing is occasioned by a Board determination) shall appoint a Hearing Panel which shall be composed of not fewer than three members. The majority of the Hearing Panel shall be composed of Medical Staff appointees who shall not have actively participated in the consideration of the matter involved at any previous level. If the grounds for the hearing involve an individual’s staff membership and/or clinical privileges at Hospital only, then all of the members of the Hearing Panel shall be members of Hospital's Medical Staff.
3. The Hearing Panel shall not include any individual who is in direct economic competition with the affected person or any such individual who is professionally associated with or related to the affected individual. Such appointment shall include designation of the Chairperson or the Presiding Officer. Knowledge of the matter involved shall not preclude any individual from serving as a member of the Hearing Panel.
4. Presiding Officer:
5. In lieu of a Hearing Panel Chairperson, the President of the Hospital may appoint an attorney at law as Presiding Officer. Such Presiding Officer may not be legal counsel to the Hospital, and must not act as a prosecuting officer, or as an advocate for either side at the hearing. The Presiding Officer may participate in the private deliberations of the Hearing Panel and be a legal advisor to it, but shall not be entitled to vote on its recommendations.
6. If no Presiding Officer has been appointed, a Chairperson of the Hearing Panel shall be appointed by the President of the Hospital and President of the Medical Staff, shall serve as the Presiding Officer, and shall be entitled to one vote in the case of a tie vote.
7. The Presiding Officer (or Hearing Panel Chairperson) shall:
	1. act to ensure that all participants in the hearing have a reasonable opportunity to be heard and to present oral and documentary evidence subject to reasonable limits on the number of witnesses and duration of direct and cross examination, applicable to both sides, as may be necessary to avoid cumulative or irrelevant testimony or to prevent abuse of the hearing process;
	2. maintain decorum throughout the hearing;
	3. determine the order of procedure throughout the hearing;
	4. have the authority and discretion, in accordance with these Bylaws, to make rulings on all questions which pertain to matters of procedure and to the admissibility of evidence;
	5. act in such a way that all information reasonably relevant to the continued appointment or clinical privileges of the individual requesting the hearing is made available to and considered by the Hearing Panel in formulating its recommendations; and
	6. conduct argument by counsel on procedural points outside the presence of the Hearing Panel unless the Panel wishes to be present.

(4) The Presiding Officer may be advised by legal counsel to the Hospital.

## ARTICLE V – PART C: HEARING PROCEDURE

## ARTICLE IV - PART C: HEARING PROCEDURE

### Section 1. Pre-Hearing Discovery

1. There is no right to pre-hearing discovery. The individual requesting the hearing shall be entitled, upon specific request, to the following, subject to a stipulation signed by both parties that such documents shall be maintained as confidential and shall not be disclosed or used for any purpose outside of the hearing:
2. copies of or reasonable access to all patient medical records referred to in the Statement of Reasons, at his or her expense;
3. reports of experts relied upon by the Joint Credentials Committee;
4. copies of redacted relevant committee or department minutes (such provision does not constitute a waiver of the state peer review protection statute); and
5. copies of any other documents relied upon by the Joint Credentials Committee.
6. Prior to the hearing, on dates set by the Hearing Officer or agreed upon by counsel for both sides, each party shall provide the other party with a list of proposed exhibits. All objections to documents or witnesses to the extent then reasonably known, shall be submitted in writing in advance of the hearing. The Hearing Officer shall not entertain subsequent objections unless the party offering the objection demonstrates good cause.
7. There shall be no contact by the person requesting the hearing or his/her attorney with Hospital employees appearing on Hospital's witness list, unless specifically agreed upon by counsel.
8. There shall be no contact between the Hospital employees and anyone on the practitioner’s witness list, unless specifically agreed upon by the counsel.

**ARTICLE V – PART C: HEARING PROCEDURE**

### Section 2. Failure to Appear

Failure, without good cause, of the individual requesting the hearing to appear and proceed at such a hearing shall be deemed to constitute voluntary acceptance of the recommendations or actions pending, which shall then become final and effective immediately.

**ARTICLE V – PART C: HEARING PROCEDURE**

### Section 3. Record of Hearing

The Hearing Panel shall maintain a record of the hearing by a reporter present to make a record of the hearing or a recording of the proceedings. The cost of such reporter shall be borne by the Hospital, but copies of the transcript shall be provided to the individual requesting the hearing at that individual's expense. The Hearing Panel may, but shall not be required to, order that oral evidence shall be taken only on oath or affirmation administered by any person designated by such body and entitled to notarize documents in this State.

**ARTICLE V – PART C: HEARING PROCEDURE**

### Section 4. Rights of Both Sides

1. At a hearing, both sides shall have the following rights, subject to reasonable limits determined by the Presiding Officer:
2. to call and examine witnesses to the extent available;
3. to introduce exhibits;
4. to cross-examine any witness on any matter relevant to the issues and to rebut any evidence;
5. To be represented by counsel who may call, examine, and cross-examine witnesses and present the case. Both sides shall notify the other of the name of that counsel at least 10 days prior to the date of the hearing; and
6. Any individuals requesting a hearing who do not testify in their own behalf may be called and examined as if under cross-examination.

**ARTICLE V – PART C: HEARING PROCEDURE**

### Section 5. Admissibility of Evidence

The hearing shall not be conducted according to rules of law relating to the examination of witnesses or presentation of evidence. Any relevant evidence shall be admitted if it is the sort of evidence on which responsible persons are accustomed to rely in the conduct of serious affairs, regardless of the admissibility of such evidence in a court of law. Each party shall have the right to submit a memorandum of points and authorities, and the Hearing Panel may request such a memorandum to be filed, following the close of the hearing. The Hearing Panel may interrogate the witnesses, call additional witnesses, or request documentary evidence if it deems it appropriate.

**ARTICLE V – PART C: HEARING PROCEDURE**

### Section 6. Official Notice

The Presiding Officer shall have the discretion to take official notice of any matters, either technical or scientific, relating to the issues under consideration that could have been judicially noticed by the courts of the State of Georgia. Participants in the hearing shall be informed of the matters to be officially noticed and such matters shall be noted in the record of the hearing. Either party shall have the opportunity to request that a matter be officially noticed or to refute the noticed matter by evidence or by written or oral presentation of authority. Reasonable additional time shall be granted, if requested, to present written rebuttal of any evidence admitted on official notice.

**ARTICLE V – PART C: HEARING PROCEDURE**

## ARTICLE IV - PART C: HEARING PROCEDURE

### Section 7. Postponements and Extensions

Postponements and extensions of time beyond any time limit set forth in these Bylaws may be requested by anyone, but shall be permitted only by the Hearing Panel, its Chairperson, or the entity which appointed the Hearing Panel on a showing of good cause.

## ARTICLE V – PART D: HEARING CONCLUSION, DELIBERATIONS AND RECOMMENDATIONS

## ARTICLE IV - PART D: HEARING CONCLUSION, DELIBERATIONS AND RECOMMENDATIONS

### Section 1. Burden of Proof

1. The Board or the Joint Credentials Committee, depending on whose recommendation prompted the hearing initially, shall first come forward with evidence in support of its recommendation. Thereafter, the burden shall shift to the individual who requested the hearing to come forward with evidence.
2. After all the evidence has been submitted by both sides, the Hearing Panel shall recommend in favor of the Joint Credentials Committee, and/or the Board, unless it finds that the individual who requested the hearing has proved that the recommendation that prompted the hearing was arbitrary, capricious, or not sustained by substantial evidence.

**ARTICLE V – PART D: HEARING CONCLUSION, DELIBERATIONS AND RECOMMENDATIONS**

### Section 2. Basis of Decision

The decision of the Hearing Panel shall be based on the evidence produced at the hearing. This evidence may consist of the following:

1. oral testimony of witnesses;
2. memorandum of points and authorities presented in connection with the hearing;
3. any information regarding the individual who requested the hearing so long as that information has been admitted into evidence at the hearing and the person who requested the hearing had the opportunity to comment on and, by other evidence, refute it;
4. any and all applications, references, and accompanying documents;
5. other documented evidence, including medical records; and
6. any other evidence that has been admitted.

**ARTICLE V – PART D: HEARING CONCLUSION, DELIBERATIONS AND RECOMMENDATIONS**

### Section 3. Adjournment and Conclusion

The Presiding Officer may adjourn the hearing and reconvene the same at the convenience and with the agreement of the participants without special notice. Upon conclusion of the presentation of oral and written evidence, the hearing shall be closed.

**ARTICLE V – PART D: HEARING CONCLUSION, DELIBERATIONS AND RECOMMENDATIONS**

### Section 4. Deliberations and Recommendation of Hearing Panel

Within 20 days after final adjournment of the hearing, the Hearing Panel shall conduct its deliberations outside the presence of any other person (except the Presiding Officer, if one is appointed) and shall render a recommendation, accompanied by a report, which shall contain a concise statement of the reasons justifying the recommendation made and shall deliver such report to the President of the Hospital. Should any panel member be absent from any part of the hearing, they must document review of a transcript of said portion of the hearing, or shall be required to recuse themselves from deliberations.

**ARTICLE V – PART D: HEARING CONCLUSION, DELIBERATIONS AND RECOMMENDATIONS**

### Section 5. Disposition of Hearing Panel Report

Upon its receipt, the President of the Hospital shall forward the Hearing Panel's report and recommendation, along with all supporting documentation, to the Board for further action by the Board of each Hospital where the report and recommendation concerns the medical staff appointment and/or clinical privileges of the person requesting the hearing. The President of the Hospital shall also send a copy of the report and recommendation, certified mail, return receipt requested, to the individual who requested the hearing, and to the Joint Credentials Committee for information and comment.

## ARTICLE V – PART E: APPEAL PROCEDURE

## ARTICLE IV - PART E: APPEAL PROCEDURE

### Section 1. Time for Appeal

Within 10 days after notice of the Hearing Panel's recommendation, either party may request an appellate review. The request shall be in writing, and shall be delivered to the President of the Hospital, either in person or by certified mail, and shall include a brief statement of the reasons for appeal. If such appellate review is not requested within 10 days as provided herein, both parties shall be deemed to have accepted the recommendation involved and it shall thereupon become final and immediately effective.

**ARTICLE V – PART E: APPEAL PROCEDURE**

### Section 2. Grounds for Appeal

The grounds for appeal shall be that:

1. there was substantial failure to comply with the bylaws of the Hospital or Medical Staff in the matter which was the subject of the hearing so as to deny due process or a fair hearing; or
2. the recommendations were made arbitrarily, capriciously, or with prejudice; or
3. the recommendations were not supported by substantial evidence.

**ARTICLE V – PART E: APPEAL PROCEDURE**

### Section 3. Time, Place, and Notice

Whenever an appeal is requested as set forth in the preceding sections, the Chairperson of the Board shall, within 10 days after receipt of such request, schedule and arrange for an appellate review. The affected individual shall be given notice of the time, place, and date of the appellate review. The date of appellate review shall be not fewer than 10 days, nor more than 30 days from the date of receipt of the request for appellate review; provided, however, that when a request for appellate review is from an appointee who is under a suspension then in effect the appellate review shall be held as soon as the arrangements may reasonably be made and not more than 14 days from the date of receipt of the request for appellate review. The time for appellate review may be extended by the Chairperson of the Board for good cause.

**ARTICLE V – PART E: APPEAL PROCEDURE**

### Section 4. Nature of Appellate Review

1. The Chairperson of the Board shall appoint a Review Panel composed of not fewer than three persons, either members of the Board or others, including but not limited to reputable persons outside the Hospital, to consider the record upon which the recommendation was made.
2. The Review Panel may accept additional oral or written evidence subject to the same rights of cross-examination or confrontation provided at the Hearing Panel proceedings. Such additional evidence shall be accepted only if the party seeking to admit it can demonstrate that any opportunity to admit it at the hearing was denied, and then only at the discretion of the Review Panel.
3. Each party shall have the right to present a written statement in support of its position on appeal, and in its sole discretion, the Review Panel may allow each party or its representative to appear personally and make oral argument. The Review Panel shall recommend final action to the Board.
4. The Board may affirm, modify, or reverse the recommendation of the Review Panel or, in its/their discretion, refer the matter for further review and recommendation.

**ARTICLE V – PART E: APPEAL PROCEDURE**

### Section 5. Final Decision of the Board

Within 30 days after receipt of the Review Panel's recommendation, the Board shall render a final decision in writing and shall deliver copies thereof to the affected individual, the Chairperson of the Joint Credentials Committee, and the Chairperson of its MEC, in person or by certified mail, return receipt requested.

**ARTICLE V – PART E: APPEAL PROCEDURE**

### Section 6. Further Review

Except where the matter is referred for further action and recommendation in accordance with Section 4 of this Part, the final decision of the Board following the appeal shall be effective immediately and shall not be subject to further review. Provided, however, if the matter is referred for further action and recommendation, such recommendation shall be promptly made to the Board in accordance with the instructions given by the Board. This further review process and the report back to the Board shall in no event exceed 30 days in duration except as the parties may otherwise stipulate.

**ARTICLE V – PART E: APPEAL PROCEDURE**

### Section 7. Right to One Appeal Only

No applicant or Medical Staff appointee shall be entitled as a matter of right to more than one appellate review on any single matter which may be the subject of an appeal. In the event that the Board ultimately determines to deny initial Medical Staff appointment or reappointment to an applicant, or to revoke or terminate the Medical Staff appointment and/or clinical privileges of a current appointee, that individual may not reapply for Medical Staff appointment or for those clinical privileges at Hospital unless the Board provides otherwise.

**ARTICLE VI
MEDICAL ASSISTANTS**

## ARTICLE VI – PART A: MEDICAL ASSISTANTS

## ARTICLE V - PART B: MEDICAL ASSISTANTS

### Section 1. Qualifications

Professionals who are licensed or certified practitioners approved by the Board to provide clinical services with a physician supervisor at the Hospital are eligible to practice as Medical Assistants and may apply for authority to provide clinical services within an approved scope of practice. They shall be located within the geographic service area of the Hospital, close enough to fulfill their responsibilities, and to provide timely care for their patients in the Hospital.

**ARTICLE VI – PART A: MEDICAL ASSISTANTS**

### Section 2. Application

1. Each such individual shall file an application as a Medical Assistant on a form provided by the Hospital and provide such evidence of licensure, certification, education and training, clinical competence (two (2) peer recommendations), previous employment (work history), professional liability, and any other information requested by the Hospital. The supervising physician must sign the Physician Sponsor/Employer Statement form for such individual. The Scope of Practice shall be limited to those clinical services set forth on the individual's job description, and within the scope of privileges of the supervising physician. Each such individual must provide evidence of current, valid professional liability insurance coverage in such terms and in amounts satisfactory to the Hospital. Each Medical Assistant must apply every two years for renewal of authority to provide clinical services within an approved scope of practice. Any failure by a Medical Assistant to respond to a request for information within 30 days of the request shall be deemed a withdrawal of the application and the Medical Assistant shall not be eligible to apply or reapply for authority to provide clinical services for three months following the withdrawal.
2. Licensure, certification and professional liability coverage, education and training, previous employment and sanction information shall be primary source verified by the Hospital’s Medical Staff Services Department.
3. All new applicants will undergo background verification. The applicant must complete the Combined Disclosure Notice and Authorization Form Regarding Background Consideration supplied by the approved Hospital vendor and signs and dates the authorization form. All information including residence and practice information for the past ten (10) years must be listed. The applicant is responsible for fees to cover the cost of the background verification in the amount required by the Hospital. This is a non-refundable fee and is charged in addition to the regular application fee(s). The application will be deemed incomplete until this process is completed and the Background Verification Report has been received and reviewed.
4. Any applicant making new application and/or changing physician sponsor(s) and there is less than one-year lapse of approval to provide clinical services in the Hospital must have a letter from previous employer(s) attesting to competency and citizenship. If it has been more than one year since lapse of approval to provide clinical services in the Hospital, a new background verification must be completed as described in (c) above with payment of all applicable fees.
5. Clean applications meeting the following criteria may be forwarded directly to the Chair of the Joint Credentials Committee, who is empowered to review the application and make a recommendation:
6. No more than two malpractice payments and no currently pending claims;
7. Information on application was verified without difficulty;
8. References were obtained without difficulty, indicating no problems; and
9. No reports of disciplinary action, no license restrictions, no investigations, nothing to suggest the practitioner is anything other than highly qualified in all areas.
10. The action of the chairperson shall be reported to the Joint Credentials Committee at its next meeting. Based upon this review and consultation, a recommendation shall be forwarded to the President(s) of the Medical Staff(s), acting as designee for the MEC(s), who will then forward to the President/CEO of the hospital, or designee for conditional approval. Final approvals shall be reported to the MEC(s) monthly and the Boards of both Hospitals on a quarterly basis.
11. Applications meeting the following criteria shall be forwarded to the full Joint Credentials Committee for recommendation to the MEC(s) and by the MEC to the full Board of each Hospital where the applicant has applied for approval:
	* + 1. There is a current challenge or previously successful challenge to licensure or registration;
			2. The applicant has received an involuntary termination at another organization;
			3. The applicant has received involuntary limitation, reduction, denial or loss of approval to practice;
			4. There has been a final judgment adverse to the applicant in a professional liability action, or
			5. The MEC made a final recommendation that is adverse or with limitations.
12. Each Medical Assistant must be evaluated annually by their physician sponsor for competency in performing duties as outlined in their Scope of Practice. Any Medical Assistant with “Below Standard/Needs Improvement” scoring must have a “Work Improvement Plan” and follow-up evaluation or the sponsoring physician may decide to remove the Medical Assistant.
13. Quality of care and behavior issues are forwarded for peer review in accordance with the Peer Review policy.

**ARTICLE VI – PART A: MEDICAL ASSISTANTS**

### Section 3. Certified Physicians’ Assistants and Certified Nurse Practitioners

1. Physicians' Assistants fully certified pursuant to Article 4 of the Georgia Physician's Assistant Act (or any replacement or amendment thereof) and nurses recognized by the Georgia Board of Nursing as fully certified Nurse Practitioners who provide services under the personal direction and supervision of physicians who are currently appointed to the Medical Staff of Hospital or St. Joseph’s Hospital are included in the category of Medical Assistants defined in this Article VI and shall be credentialed as provided for in this Article VI.
2. The delineation of the scope of practice or approved job description of Physicians' Assistants and Nurse Practitioners in a Hospital shall be governed by the decision of its Board upon recommendation of the Joint Credentials Committee.
3. Physicians' Assistants and Nurse Practitioners shall be under the personal direction and supervision of their supervising physician or alternate physician at all times, even though the physician may not be present at all times.
4. Physicians' Assistants and Nurse Practitioners shall be expected to comply with all policies set forth for physicians unless more restrictive policies apply to Physicians' Assistants or Nurse Practitioners.
5. Automatic termination of the authority to provide clinical services within an approved scope of practice will also occur in the event the Physician's Assistant's or Nurse Practitioner's certification is revoked by the Composite State Board of Medical Examiners.
6. If a physician supervisor's clinical privileges are altered, the Physician's Assistant's or Nurse Practitioner's job description shall be reviewed by the Joint Credentials Committee.
7. If a physician sponsor resigns from the staff or his/her privileges are otherwise terminated, the Physician Assistant’s or Nurse Practitioner’s right to practice is automatically relinquished until a replacement physician sponsor is designated and appropriate application form and Scope of Practice are signed and approved.
8. Any change in the physician supervisor or job description of a Physician's Assistant or Nurse Practitioner may be made only by application to the Hospital and the completion of a revised Scope of Practice.
9. When a Physician's Assistant or Nurse Practitioner terminates employment with a supervising physician, the physician shall advise the Hospital(s) so that approved scope of practice may be withdrawn.
10. The number of Physician's Assistants or Nurse Practitioners being supervised by a physician, as well as the acts they may undertake, shall be consistent with the applicable state statutes and regulations, the rules and regulations of the Medical Staff, and the policies of the Hospital(s).

**ARTICLE VI – PART A: MEDICAL ASSISTANTS**

### Section 4. Conditions of Practice:

1. Medical Assistants shall not be entitled to the rights, privileges, and responsibilities of appointment to the Medical Staff(s) and may only engage in acts within the scope of practice specifically granted by the Board. Medical Assistants shall practice at the discretion of the Board, and thus their applications may be granted or denied and their scope of practice may be terminated at will by a Board and shall not be covered by the due process provisions of Article V or Article VI of these Bylaws.
2. A Medical Assistant shall have the right to an explanation of any adverse recommendation within 30 days of negative action and the right to appear personally before the Joint Credentials Committee to discuss the Scope of Practice recommended by that committee before the recommendation is transmitted to the MEC(s). If the Medical Assistant does not request a review within 30 days, the appeal right is waived.
3. If a review is requested, the Medical Assistant, with or without their physician sponsor, will meet with the Department Chairperson, President of the Medical Staff or Joint Credentials Chairperson, with or without the Vice President of Medical Affairs to review the circumstances surrounding the adverse decision, present their information and provide evidence documents. Neither the Hospital nor the Medical Assistant is permitted representation by legal counsel.
4. The Medical Staff leader, as defined in Section 4(c) of Part A, Article VI above, will present a summary of findings to the Joint Credentials Committee and/or the individual may be afforded the opportunity to meet with the Joint Credentials Committee. The decision made by the Joint Credentials Committee may not be appealed.
5. The decision of the review is reported to the Joint Credentials Committee, MEC and the Board.

**ARTICLE VI – PART A: MEDICAL ASSISTANTS**

### Section 5. Other Conditions of Practice

It is the responsibility of the Medical Assistant to report any and all adverse actions taken by any State Licensing Board or Federally Funded Healthcare Programs to the Joint Credentials Committee*.*

# ARTICLE VIISTRUCTURE OF THE MEDICAL STAFF

## ARTICLE VII – PART A: GENERAL

### Section 1. Medical Staff Year

For the purpose of these Bylaws, the Medical Staff year commences on the 1st day of January and ends on the 31st day of December each year.

**ARTICLE VII – PART A: GENERAL**

### Section 2. Dues

All persons appointed to the Medical Staff (except exempted Active, Emeritus and Honorary members) shall pay dues and assessments to the Hospital's Medical Staff account as may be required by the MEC and approved by the Board from time to time. Signatories to this account shall be the President of the Medical Staff, the Secretary‑Treasurer of the Medical Staff and/or his/her designee.

## ARTICLE VII – PART B: OFFICERS

### Section 1. Officers

The officers of the Medical Staff shall be the President, President-Elect, and Secretary-Treasurer.

**ARTICLE VII – PART B: OFFICERS**

### Section 2. Qualifications of Officers and Chairpersons

Only those Active Staff members who satisfy the following criteria shall be eligible to serve as Medical Staff officers, department chairpersons, or committee chairpersons. However, with respect committee chairpersons only, the MEC and the Board, upon a showing of good cause, may elect to waive one or more particular requirements:

1. be appointed in good standing to the Medical Staff of the Hospital and continue so during the term of office;
2. have no pending adverse recommendations; concerning Staff appointment or clinical privileges;
3. have demonstrated interest in maintaining quality medical care at the Hospital;
4. not be presently practicing as the employee of another hospital or another hospital-related entity, not be receiving practice management services from another hospital or another hospital-related entity, and not be receiving compensation from another hospital or hospital-related entity (except for professional fees and except for any of the relationships in this section with St. Joseph’s Hospital);
5. (with respect to Medical Staff officers and department chairpersons only) not be presently serving as a Medical Staff or corporate officer, department or committee chairperson at another hospital, and shall not so serve during the term of office (unless in a department that is consolidated with the corresponding St. Joseph’s department or section);
6. (with respect to department chairpersons only) be certified by an appropriate specialty board, or affirmatively establish, through the privilege delineation process, that he or she possesses comparable competence;
7. have constructively participated in Medical Staff affairs, including peer review activities;
8. have actively served on at least two Medical Staff committees;
9. be willing to discharge faithfully the duties and responsibilities of the position to which the individual is elected or appointed;
10. be knowledgeable concerning the duties of the office;
11. possess written and oral communication skills; and
12. possess and have demonstrated an ability for harmonious interpersonal relationships.

Unless excepted when appointed as a committee chairperson, all Medical Staff officers, department chairpersons, and committee chairpersons must possess at least the above qualifications and maintain such qualifications during their term of office. Failure to do so shall automatically create a vacancy in the office involved.

**ARTICLE VII – PART B: OFFICERS**

### Section 3. President of the Medical Staff

The President shall:

1. serve as the chief administrative officer of the Medical Staff;
2. receive and interpret the policies of the Board to the Medical Staff and report to the Board on the performance and maintenance of quality with respect to the delegated responsibility of the Medical Staff to provide medical care;
3. serve as the chief medical officer of the Hospital,
4. act in coordination and cooperation with the President of the Hospital and/or the Vice President of the Medical Affairs in matters of mutual concern involving the Hospital;
5. call, preside at and be responsible for the agenda of all general meetings of the Medical Staff;
6. make recommendations for appointment of committee chairpersons and members, in accordance with the provisions of these Bylaws, to all standing and special Medical Staff committees except the MEC;
7. serve as Chairperson of the MEC;
8. serve as ex officio member, without vote, on all Medical Staff committees other than the MEC;
9. serve as an *ex officio* member of the Board, with vote;
10. participate in Hospital deliberations affecting the discharge of medical Staff responsibilities;
11. serve as an *ex officio* member of the SJ/CHS board, without vote, and on the Professional Relations Committee or such other committees of the SJ/CHS board as requested;
12. represent the views, policies, needs and grievances of the Medical Staff and report on the medical activities of the Staff to the Board, to the President of the Hospital and to the SJ/CHS board;
13. be responsible for the educational activities of the Medical Staff; and
14. serve as liaison between the President of the Hospital, the Board, and the Staff on medical matters and other matters affecting the Staff.

**ARTICLE VII – PART B: OFFICERS**

### Section 4. President-Elect of the Medical Staff

The President-Elect shall:

1. assume all the duties and have the authority of the President of the Medical Staff in the event of the President's temporary inability to perform due to illness, absence from the community or unavailability for any other reason;
2. serve as a member of the MEC;
3. serve as a member of the Credentials Committee and Performance Improvement Council and report their recommendations and activities to the MEC;
4. automatically succeed the President, should the office of President become vacated for any reason during the President's term of office;
5. perform such additional duties as are assigned by the President, the MEC or the Board.

**ARTICLE VII – PART B: OFFICERS**

### Section 5. Secretary-Treasurer

The Secretary‑Treasurer shall:

1. serve as a member of the MEC;
2. cause to be kept accurate and complete minutes of all MEC and Medical Staff meetings;
3. collect Staff dues and funds, make disbursements authorized by the MEC or its designees, and cause to be prepared annual financial reports or interim reports as may be requested by the President or the MEC;
4. call meetings on order of the President of the Medical Staff, attend to all correspondence and perform such other duties as pertain to the office of Secretary‑Treasurer; and
5. perform such additional duties as are assigned by the President, the MEC, or the Board.

**ARTICLE VII – PART B: OFFICERS**

### Section 6. Election of Officers

1. Nominating Committee: The Nominating Committee shall consist of five (5) Active Staff members, three of whom are appointed by the President of the Medical Staff and two of whom are elected at the Medical Staff meeting preceding the scheduled date of the next Medical Staff election. No two members of the Nominating Committee may practice within the same specialty.
2. Nomination and Election of Officers and At-Large Members: The Nominating Committee shall prepare a slate of nominees for each office and for each at‑large seat on the MEC to be filled at that election.
3. Nominations for officers of the Medical Staff shall be presented by the Nominating Committee and by any other Medical Staff member prior to each Annual Meeting.
4. Any nomination made by a Staff member other than the Nominating Committee must be submitted, in writing, to the Nominating Committee at least ten days prior to the election. In order to be included on the ballot as a candidate, each nominee must possess all the qualifications set forth in Section 2 of this Part.
5. The candidates who receive a majority vote of those Medical Staff members eligible to vote and present at the meeting at the time the vote is taken shall be elected. The election of each officer shall become effective as soon as approved by the Board.
6. Each officer shall then serve from the start of the next Medical Staff year for a term of two years or until a successor has been elected and the Board has approved that election.
7. In any election, if there are three or more candidates for an office and no candidate receives a majority vote, there shall then be successive balloting such that the name of the candidate receiving the fewest votes is omitted from each successive slate until a majority is obtained by one candidate.

**ARTICLE VII – PART B: OFFICERS**

### Section 7. Conflict of Interest

1. In any instance where an officer, department chairperson, committee chairperson, or member of any Medical Staff committee has or reasonably could be perceived to have a conflict of interest or to be biased in any matter involving another Medical Staff member that comes before such individual or committee, or in any instance where any such individual or committee member brought the complaint against that member, such individual or member shall not participate in the discussion or voting on the matter, and shall be excused from any meeting during that time, although that individual or committee member may be asked, and may answer, any questions concerning the matter before leaving. As a matter of procedure, the chairperson of that committee designated to make such a review shall inquire, prior to any discussion of the matter, whether any member has any conflict of interest or bias. Any committee member with knowledge of the matter may call the existence of a potential conflict of interest or bias on the part of any committee member to the attention of the chairperson.
2. A department chairperson shall have a duty to delegate review of applications for appointment, reappointment, or clinical privileges, or questions that may arise to a vice-chairperson, chairperson-elect or other member of the department, if the chairperson has a conflict of interest with the individual under review, or could be reasonably perceived to be biased.

**ARTICLE VII – PART B: OFFICERS**

### Section 8. Removal of Officers

1. The MEC by a two-thirds vote, may remove any Medical Staff officer, including a department chairperson, for conduct detrimental to the interests of the Hospital, or if the officer is suffering from a physical or mental infirmity that renders the individual incapable of fulfilling the duties of that office, provided that notice of the meeting at which such action shall be decided is given in writing to such officer at least ten days prior to the date of the meeting. The officer shall be afforded the opportunity to speak to the MEC prior to the taking of any vote on such removal. The removal shall be effective when approved by the Board.
2. In addition, an officer (including a department chairperson) who is found by the Board to no longer meet any of the qualifications set forth in Section 2 of this Part shall automatically relinquish his/her office.

**ARTICLE VII – PART B: OFFICERS**

### Section 9. Vacancies in Office

If there is a vacancy in the office of the President of the Medical Staff prior to the expiration of the President's term, the President-Elect shall assume the duties and authority of the President for the remainder of the unexpired term. If there is a vacancy in any other office, the MEC shall appoint another person possessing the qualifications set forth in Section 2 of this Part to serve out the remainder of the unexpired term. Such appointment shall be effective when approved by the Board.

## ARTICLE VII – PART C: MEETINGS OF THE MEDICAL STAFF

### Section 1. Annual Staff Meeting

The last regular Medical Staff meeting before the end of the Staff year shall be the Annual Meeting at which officers for the ensuing year shall be elected.

**ARTICLE VII – PART C: MEETINGS OF THE MEDICAL STAFF**

### Section 2. Regular Staff Meetings

The Medical Staff shall hold regular meetings at least twice a year, on dates set at the beginning of the year by the President of the Medical Staff, for the purpose of reviewing and evaluating departmental and committee reports and recommendations, and to act on any other matters placed on the agenda by the President. One of these meetings shall be the Annual meeting.

**ARTICLE VII – PART C: MEETINGS OF THE MEDICAL STAFF**

### Section 3. Special Staff Meeting and Actions Without Meetings

Special meetings of the Medical Staff may be called at any time by the President of the Medical Staff, a majority of the MEC, or a petition signed by not less than one‑fourth of the voting Staff. Written notice stating the time place and purpose of any special meeting shall be conspicuously posted and shall be sent to each Staff member at least ten business days before the date of such meeting. The attendance of a Staff member at a meeting shall constitute a waiver of notice of such meeting. No business shall be transacted at any special meeting except that stated in the notice of such meeting. In the event that it is necessary for the Staff to act on a question without being able to meet, the voting Staff may be presented with the question by mail and their votes returned to the President by mail. Such a vote shall be valid so long as the question is voted on by a majority of the Staff eligible to vote.

**ARTICLE VII – PART C: MEETINGS OF THE MEDICAL STAFF**

### Section 4. Quorum

The presence, which presence may be physical or virtual, of ten percent (10%) of the persons eligible to vote shall constitute a quorum for the purposes of (i) election of medical staff officers and (ii) amendments to the Bylaws. For all other regular or special meetings of the Medical Staff a quorum shall be defined as all members present at such meeting. Once a quorum is established, the business of the meeting may continue and all actions taken shall be binding even though less than a quorum exists at a later time in the meeting.

**ARTICLE VII – PART C: MEETINGS OF THE MEDICAL STAFF**

### Section 5. Agenda

The agenda at any regular or special Medical Staff meeting and its conduct shall be set by the President of the Medical Staff.

## ARTICLE VII – PART D: DEPARTMENT AND COMMITTEE MEETINGS

### Section 1. Department Meetings

Members of each department shall meet as a department not less than two times a year at times set by the chairperson of the department to review and evaluate the clinical work of the department, to consider the findings of ongoing performance improvement activities, and to discuss any other matters concerning the department. The agenda for the meeting and its general conduct shall be set by the chairperson. Each department shall maintain a permanent record of its findings, proceedings and actions, and shall make a report thereof, after each meeting to the MEC and the President of the Hospital.

**ARTICLE VII – PART D: DEPARTMENT AND COMMITTEE MEETINGS**

### Section 2. Committee Meetings

All committees shall meet as often as necessary to fulfill their responsibilities, at times set by the chairperson of the committee. The chairperson shall set the agenda for the meeting and its general conduct. Each committee shall maintain a permanent record of its findings, proceedings and actions, and shall make a report thereof, after each meeting to the MEC and the President of the Hospital.

**ARTICLE VII – PART D: DEPARTMENT AND COMMITTEE MEETINGS**

### Section 3. Special Department and Committee Meetings

1. A special meeting of any department or committee may be called by or at the request of the appropriate chairperson, the President of the Medical Staff, or by a petition signed by not less than one‑fourth of the members of the department or committee.
2. In the event that it is necessary for a department or committee to act on a question without being able to meet, the voting members may be presented with the question, in person or by mail, and their vote returned to the chairperson of the department or committee. Such a vote shall be binding so long as the question is voted on by a majority of the department or committee eligible to vote.

**ARTICLE VII – PART D: DEPARTMENT AND COMMITTEE MEETINGS**

### Section 4. Quorum

The presence, which presence may be physical or virtual, of ten percent (10%) of the total membership of the department or committee eligible to vote at any regular or special meeting (but in no event less than two members) shall constitute a quorum for the purposes of the election of department or committee officers. For all other regular or special meetings of the department or committee a quorum shall be defined as all members present at such meeting. Once a quorum is established, the business of the meeting may continue and all actions taken shall be binding even though less than a quorum exists at a later time in the meeting.

**ARTICLE VII – PART D: DEPARTMENT AND COMMITTEE MEETINGS**

### Section 5. Minutes

Minutes of each meeting of each department and each committee shall be prepared and shall include a record of the attendance of members, of the recommendations made, and of the pass/fail vote taken on each matter. The presiding officer shall sign the minutes and copies thereof shall be promptly forwarded to the MEC and the President of the Hospital and certain committees as specified elsewhere in these Bylaws. A permanent file of the minutes of each department and each committee meeting shall be maintained by the Hospital.

## ARTICLE VII – PART E: PROVISIONS COMMON TO ALL MEETINGS

### Section 1. Notice of Meetings

Notice of all meetings of the Medical Staff and regular meetings of departments and committees shall be posted on the Medical Staff bulletin board, and delivered, either in person or by mail, to each Staff member at least ten (10) working days in advance of such meetings. Such notice shall state the date, time, and place of the meeting. When mailed, the notice shall be deemed delivered when deposited, postage prepaid, in the United States mail addressed to each member at his or her address as it appears on the records of the Hospital. Such posting and mailing shall be deemed to constitute actual notice to the persons concerned. The attendance of any individual at any meeting shall constitute a waiver of that individual's notice of said meeting.

**ARTICLE VII – PART E: PROVISIONS COMMON TO ALL MEETINGS**

### Section 2. Attendance Requirements

1. Any Medical Staff member whose clinical work is scheduled for discussion at a regular departmental meeting shall be so notified and shall be expected to attend such meeting.
2. Whenever a Medical Staff or department educational program is prompted by findings of quality assessment/improvement activities, the Staff member whose performance prompted the program shall be notified and shall be expected to attend such meeting.
3. Whenever a pattern of suspected deviation from standard clinical or professional practice is identified, the President or the applicable department chairperson may require the Medical Staff member to confer with the chairperson or with a standing or ad hoc committee considering the matter.
4. The department chairperson shall give the individual at least five days prior written notice of the date, time and place of any meeting at which attendance is expected. Whenever apparent or suspected deviation from standard clinical practice is involved, the notice to the individual shall include a statement of the issue involved and notice that the individual’s attendance is mandatory. The notice shall be given by certified mail, return receipt requested.
5. If the individual shall make a timely request for postponement, supported by an adequate showing that the absence will be unavoidable, the presentation may be postponed by the department chairperson, or by the MEC if the department chairperson is the individual involved, until not later than the next regularly scheduled meeting. Otherwise, the pertinent clinical information shall be presented and discussed as scheduled.
6. The chairperson of the applicable department shall notify the MEC of the failure of an individual to attend any meeting with respect to which notice was given that attendance was mandatory. Unless excused by the MEC upon showing of good cause, such failure shall constitute voluntary relinquishment of all or such portion of the individual's clinical privileges as the MEC may direct. Such voluntary relinquishment shall remain in effect until the matter is resolved by subsequent action by the MEC and the Board. Such resolution shall be made within ten (10) business days.

**ARTICLE VII – PART E: PROVISIONS COMMON TO ALL MEETINGS**

### Section 3. Rules of Order

Wherever they do not conflict with these Bylaws, the currently revised Robert's Rules of Order shall govern all meetings and elections.

**ARTICLE VII – PART E: PROVISIONS COMMON TO ALL MEETINGS**

### Section 4. Voting

Any individual who, by virtue of position, attends a meeting in more than one capacity shall be entitled to only one vote.

**ARTICLE VII – PART E: PROVISIONS COMMON TO ALL MEETINGS**

### Section 5. Majority Vote

Except as otherwise provided, the vote of a majority of the Medical Staff and of any department, section or committee of the Medical Staff shall be the action of the Staff, department, section or committee.

**ARTICLE VII – PART E: PROVISIONS COMMON TO ALL MEETINGS**

### Section 6. Participation by President of the Hospital

The President of the Hospital and any representative assigned by the President of the Hospital may attend any meeting of the Medical Staff, and any of its departments, sections or committees.

**ARTICLE VII – PART E: PROVISIONS COMMON TO ALL MEETINGS**

### Section 7. Rights of *Ex Officio* Members

Except as otherwise provided, persons serving as *ex officio* members of a committee shall have all rights and privileges of regular members thereof, except they shall not vote or hold office.

# ARTICLE VIIICLINICAL DEPARTMENTS

## ARTICLE VIII – PART A: CLINICAL DEPARTMENTS

### Section 1. Organization of Departments

1. Each department shall be organized as a separate part of the Medical Staff and shall have a chairperson who (1) is selected as set forth in these Bylaws, and (2) has the authority, duties, and responsibilities as set forth in these Bylaws.
2. An up-to-date list of departments and sections of the Medical Staff are set forth in the Medical Staff Organization and Functions Manual.

**ARTICLE VIII – PART A: CLINICAL DEPARTMENTS**

### Section 2. Creation and Dissolution of Departments and Sections

1. The MEC will periodically assess the Hospital's departmental structure and recommend to the Board whether any action is desirable (creating new, combining or eliminating departments or sections, combining the functions of departments or sections with the corresponding department or section at St. Joseph’s, etc.) for better organizational efficiency and improved patient care.
2. The following factors shall be considered by the MEC and the Board in determining whether the creation of a department or a section is warranted:
3. there are at least five (5) Medical Staff members, who are available for appointment to the department or section; and
4. the level of clinical activity that will be affected by the new department or section is substantial enough to warrant imposing the responsibility to accomplish departmental and section functions on a routine basis.
5. The following factors shall be considered by the MEC and the Board in determining whether the elimination of a department or section is warranted:
6. there is no longer an adequate number of Medical Staff members in the department or section to enable it to accomplish the functions set forth in these Bylaws;
7. there is an insubstantial number of patients or an insignificant amount of clinical activity to warrant the imposition of the designated duties on the members in the department or section;
8. the department or section fails to meet at least twice per year;
9. the department or section fails to fulfill all department or section responsibilities and functions; or
10. no qualified individual is willing to serve as chairperson.

**ARTICLE VIII – PART A: CLINICAL DEPARTMENTS**

### Section 3. Functions of Departments

1. Each clinical department chairperson shall recommend to the Credentials Committee written criteria for the assignment of clinical privileges within the department and each of its sections. The criteria are designed to assure the Medical Staff and Board that patients will receive quality care. Such criteria shall be consistent with and subject to the bylaws, policies, rules and regulations of the Medical Staff and the Hospital. These criteria shall be effective when approved by the Board. Clinical privileges shall be based upon demonstrated competence, training, and experience within the specialties covered by the department.
2. Each department or section shall monitor and evaluate medical care on a retrospective, concurrent and prospective basis in all major clinical activities of the department or section. This monitoring and evaluation may be done either departmentally or in a multi-specialty manner but must at least include:
3. the identification and collection of information about important aspects of patient care provided in the department;
4. the identification of the indicators used to monitor the quality and appropriateness of the important aspects of care; and
5. the periodic assessment of patient care information to evaluate the quality and appropriateness of care; to evaluate patient care outcomes; to identify opportunities to improve care; and to identify important problems in patient care.
6. Each department or section shall recommend, subject to approval and adoption by the MEC and Board, objective criteria that reflect current knowledge and clinical experience. These criteria shall be used by each department or section or by the Hospital's performance improvement program in the monitoring and evaluation of patient care. When important problems in patient care and clinical performance or opportunities to improve care are identified, each department or section shall document the actions taken and evaluate the effectiveness of such actions.
7. Each relevant department or section shall either conduct or supervise a comprehensive review to examine justification of surgery performed, whether tissue was removed or not, and to evaluate the acceptability and the quality of the procedure chosen for the surgery. Specific consideration shall be given to cases involving complications and to the agreement or disagreement of the pre-operative and post-operative (including pathological) diagnoses. Written reports shall be maintained reflecting the results of all evaluations performed and actions taken.
8. In discharging these functions, each department and section shall report after each meeting to the appropriate Utilization Review Committee and/or Performance Improvement Council detailing its analysis of patient care and to the Credentials Committee whenever further evaluation and action is indicated, involving any individual member of the department. Copies of these reports shall be filed with the MEC and the President of the Hospital.

**ARTICLE VIII – PART A: CLINICAL DEPARTMENTS**

### Section 4. Department Chairpersons

1. The chairperson of each department shall be a member of the Active Staff who possesses the qualifications set forth in Section 2 of Part B, Article VII and is willing and able to discharge the functions of the office.
2. The chairperson of each department shall be appointed by the Board after considering the recommendations of the department and the MEC. Initial appointment of a chairperson shall be made for a period of two years. Reappointment by the Board may be made thereafter. A chairperson-elect or vice-chairperson of each department shall be appointed by the Board after receiving the recommendation of the department and the MEC. The tenure of the chairperson-elect or vice-chairperson shall coincide with that of the chairperson. The chairperson-elect or vice-chairperson may be recommended by the department to succeed the chairperson.

**ARTICLE VIII – PART A: CLINICAL DEPARTMENTS**

### Section 5. Functions of Department Chairpersons

Each chairperson shall:

1. be responsible for all clinically related activities within the department;
2. be responsible for all administratively related activities within the department unless otherwise provided by the Hospital;
3. be a member of the MEC;
4. be responsible for the continuing surveillance of the professional performance and performance improvement of all individuals who have delineated clinical privileges in the department, and report thereon to the Credentials Committee as part of the reappointment process and at such other times as may be indicated;
5. be responsible for enforcement within the department of the Hospital policies and bylaws and the Medical Staff bylaws, policies, rules and regulations;
6. be responsible for the integration of the department into the primary functions of the Hospital;
7. be responsible for the coordination and integration of interdepartmental and intradepartmental services;
8. be responsible for implementation within the department of actions taken by the Board and the MEC;
9. be responsible for the development and implementation of policies and procedures that guide and support the provision of services;
10. make a report to the Credentials Committee concerning the appointment, reappointment, and delineation of clinical privileges for each applicant seeking privileges in the department;
11. be responsible for the establishment and implementation of any teaching, education, and research programs in the department, including the orientation and continuing education of all persons in the department;
12. be responsible for the determination of the qualifications and competence of department or service personnel who are not licensed independent practitioners and who provide patient care services;
13. report and recommend to Hospital management when necessary with respect to matters affecting patient care in the department, including recommendations for a sufficient number of qualified and competent persons to provide care or services, supplies, special regulations, standing orders and techniques;
14. assist the Hospital management in the preparation of annual reports and such budget planning pertaining to the department as may be required by the President of the Hospital or the Board;
15. provide Hospital management with recommendations for space and other resources needed by the department;
16. delegate to a chairperson-elect or vice-chairperson of the department such duties as appropriate;
17. establish sections or services within the department and appoint chairpersons thereof, subject to the approval of the MEC and the Board;
18. be responsible for the continuous assessment and improvement of the quality of care and services provided;
19. be responsible for the maintenance of quality control programs, as appropriate;
20. appoint a nominating committee to prepare a slate for the election of the chairperson and chairperson-elect or vice-chairperson; and
21. assess and recommend to the President of the Hospital off site sources for needed patient care services not provided by the department or Hospital.
22. be responsible for assignment of emergency service care for unassigned patients.

**ARTICLE VIII – PART A: CLINICAL DEPARTMENTS**

### Section 6. Section Chairpersons

1. The chairperson of each section shall be a member of the Active Staff who is qualified by training, experience, and administrative ability for the position and who meets the criteria set forth in Section 2 of Part B, Article VII.
2. The chairperson of each section shall be approved by the Board after being appointed by the department chairperson. The tenure of the chairpersons shall coincide with that of the department chairperson. A chairperson-elect or vice-chairperson of each section (if desired by the section) shall be appointed by the chairperson and approved by the MEC and the Board. The tenure of the chairperson-elect or vice-chairperson shall coincide with that of the chairperson. The chairperson-elect or vice-chairperson may succeed the chairperson in office.
3. Removal of a section chairperson during a term of office shall be in the same manner as removal of a department chairperson.

**ARTICLE VIII – PART A: CLINICAL DEPARTMENTS**

### Section 7. Functions of Section Chairpersons

Each section chairperson shall:

1. be responsible for administrative activities within the section;
2. maintain continuing surveillance of the professional performance of all individuals who have delineated clinical privileges in the section;
3. recommend criteria for clinical privileges within the section;
4. review the professional performance of all individuals with clinical privileges in the section and report and recommend thereon to the department chairperson as part of the reappointment process and at such other times as may be indicated;
5. be responsible for implementation within the section of actions taken by the Board, the MEC, and the department chairperson;
6. make reports to the department chairperson concerning the appointment and delineation of clinical privileges for all applicants seeking privileges in the section;
7. be responsible for the establishment, implementation and effectiveness of the teaching, education and research program in the section; and
8. delegate to a chairperson-elect or vice-chairperson of the section such duties as are appropriate.

# ARTICLE IX COMMITTEES OF THE MEDICAL STAFF

## ARTICLE IX – PART A: APPOINTMENT

### Section 1. Chairpersons

All committee chairpersons, unless otherwise provided for in these Bylaws, will be appointed after receiving and considering recommendations from the President of the Medical Staff. All chairpersons shall be selected based on the criteria set forth in Section 2 of Part B, Article VII. Such appointments will be made for an initial term of two years.

**ARTICLE IX – PART A: APPOINTMENT**

### Section 2. Members

1. Except as otherwise provided for in these Bylaws, members of each committee shall be appointed yearly by the President of the Medical Staff, in consultation with the President of the Hospital, not more than ten (10) days after the end of the Medical Staff year, and there shall be no limitation in the number of terms they may serve. All appointed members may be removed and vacancies filled at the discretion of the President of the Medical Staff.

## ARTICLE IX – PART B: MEDICAL EXECUTIVE COMMITTEE

### Section 1. Composition

1. The MEC shall consist of the President of the Medical Staff, the President Elect of the Medical Staff, the Immediate Past President of the Medical Staff, the Co-Chairman of the Joint Credentials Committee, the Secretary/Treasurer of the Medical Staff; the chairperson of each clinical department; and three at-large physician members elected from the General Medical Staff. The President of the Hospital shall be an *ex officio* member, without vote.
2. No member of the Active Staff shall be ineligible to serve on the MEC solely because of his or her professional discipline or specialty.
3. The MEC members at large shall be elected at the annual Medical Staff meeting. Members at‑large shall be eligible for re‑election.
4. The President of the Medical Staff shall be chairperson of the MEC.
5. The Chairperson of the Board may attend meetings of the MEC and participate in its discussions, but without vote.

**ARTICLE IX – PART B: MEDICAL EXECUTIVE COMMITTEE**

### Section 2. Duties

The Medical Executive Committee is delegated authority over activities related to the Medical Staff and its performance improvement activities. Such authority may be removed or modified by valid amendment to these Bylaws.

The duties of the MEC shall be:

1. to represent and to act on behalf of the Medical Staff in all matters in the intervals between meetings, without requirement of subsequent approval by the Staff, subject only to any limitations imposed by these Bylaws;
2. to coordinate the activities and general policies of the Medical Staff and its various departments;
3. to be responsible for supervising and coordinating the Performance Improvement and Risk Management activities of the Hospital;
4. to receive and to act upon those committee reports as specified in these Bylaws and the Medical Staff policies and to make recommendations concerning them directly to the Board, including but not limited to the following:
5. the Medical Staff’s structure as reflected in these Bylaws or the Organization and Functions Manual
6. the mechanism used to review credentials and to delineate individual clinical privileges
7. recommendations of individuals for Medical Staff membership
8. recommendations for delineated clinical privileges for each eligible individual
9. the participation of the medical Staff in organization performance improvement activities
10. the mechanism by which medical Staff membership may be terminated, and
11. the mechanism for fair hearing procedures;
12. to implement policies of the Hospital that affect the Medical Staff;
13. to implement policies of the Medical Staff not otherwise the responsibility of the departments
14. to provide liaison among the Medical Staff, the President of the Hospital, and the Board;
15. to keep the Medical Staff abreast of applicable accreditation and regulatory requirements affecting the Hospital;
16. to monitor the correction of any cited deficiencies resulting from inspection by The Joint Commission, and compliance with The Joint Commission directives;
17. to fulfill the Medical Staff organization’s accountability to the Board for the medical care of patients in the Hospital;
18. to enforce Hospital and Medical Staff rules in the best interest of patient care and of the Hospital, with regard to all persons who hold appointment to the Medical Staff;
19. to take all reasonable steps to ensure professionally ethical conduct and competent clinical performance by all persons with clinical privileges, referring situations involving questions of the clinical competence, patient care and treatment, case management, or inappropriate behavior of any Medical Staff member to the Credentials Committee for appropriate action;
20. to be responsible to the Board for the implementation of the Hospital's performance improvement plan as it affects the Medical Staff;
21. to review the bylaws, policies, rules and regulations, and associated documents of the Medical Staff at least once every five years and recommend such changes as may be necessary or desirable including those necessary to reflect the Hospital’s current practices with respect to medical Staff organizations and functions;
22. if significant changes are made in the Medical Staff bylaws, rules, or policies, assure that Medical Staff members and other individuals who have delineated clinical privileges are provided with revised texts of the written materials;
23. to conduct such other functions as are necessary for the effective operation of the Medical Staff;
24. to determine minimum continuing education requirements for members of the Staff; and
25. to report at each general Staff meeting.

**ARTICLE IX – PART B: MEDICAL EXECUTIVE COMMITTEE**

### Section 3. Meetings, Reports and Recommendations

The MEC shall meet at least ten times per year or more often if necessary to transact pending business. Copies of all minutes and reports of the MEC shall be transmitted to the President of the Hospital routinely as prepared. Recommendations of the MEC shall be transmitted to the Board with a copy to the President of the Hospital. The Chairperson of the MEC shall be available to meet with the Board on all recommendations that the MEC may make.

## ARTICLE IX – PART C: CREDENTIALS COMMITTEE

### Section 1. Composition

The Credentials Committee shall consist of:

1. the four (4) most recent past Presidents (two from each Hospital). The two most senior of these shall serve as Co-Chairperson(s) (one from each Hospital),
2. one (1) President – Elect from each Hospital (a total of 2),
3. the immediate past Co-Chairpersons of the Credentials Committee for a two year term (a total of 2)
4. Two additional members, nominated by the President of the Medical Staff, who represent specialties not represented by the other members of the Committee from each Hospital, if possible (a total of 4), for term of two years,
5. one At-Large member who shall be the current Chairperson for the Medical Staff Advisory Committee, for a term of two years.
6. The Credentials Committee shall meet with the St. Joseph’s Medical Staff Credentials Committee as one joint committee comprised of the members of each Medical Staff’s Credentials Committee

**ARTICLE IX – PART C: CREDENTIALS COMMITTEE**

### Section 2. Duties

The duties of the Credentials Committee shall be:

1. to review the credentials of all applicants for Medical Staff appointment, reappointment, and clinical privileges, to make evaluations of and interview such applicants as may be necessary, and to make a written report of its findings and recommendations;
2. to review the credentials of all applicants who request to practice at the Hospital as Medical Associates and Medical Assistants, to make evaluations of and interview such applicants as may be necessary, and to make a written report of its findings and recommendations;
3. to review, as questions arise, all information available regarding the clinical competence and behavior of persons currently appointed to the Medical Staff and of those practicing as Medical Associates and Medical Assistants and, as a result of such review, to make a written report of its findings and recommendations; and
4. to review clinical department recommendations for written criteria for the assignment of clinical privileges and to make a written report of its recommendations to the MEC.

**ARTICLE IX – PART C: CREDENTIALS COMMITTEE**

### Section 3. Meetings, Reports and Recommendations

The Credentials Committee shall meet as often as necessary to accomplish its duties but not less than every two months, shall maintain a permanent record of its proceedings and actions, and shall report its recommendations to the MEC and the President of the Hospital. The Co-Chairperson of the Credentials Committee shall be available to meet with the Board on all recommendations that the Credentials Committee may make.

## ARTICLE IX – PART D: BYLAWS COMMITTEE

### Section 1. Composition

The Bylaws Committee shall consist of a co-chairperson and three additional experienced Active Staff members who possess the qualifications set forth in Section 2 of Part B, Article VII, are recommended by the President of the Medical Staff, and approved by the Board.

**ARTICLE IX – PART D: BYLAWS COMMITTEE**

### Section 2. Duties

The Bylaws Committee shall annually review the Bylaws, and any other associated documents and recommend amendments as appropriate to the MEC to reflect the Hospital’s current practices and requirements.

**ARTICLE IX – PART D: BYLAWS COMMITTEE**

### Section 3. Meetings

1. The Bylaws Committee shall meet as often as necessary to accomplish its purposes, but at least annually.
2. The Bylaws Committee shall work to assure uniformity in patient care policies and other procedures.

## ARTICLE IX – PART E: PERFORMANCE IMPROVEMENT AND OTHER FUNCTIONS PERFORMED BY MEDICAL STAFF COMMITTEES

A description of other Medical Staff committees that carry out performance improvement functions and other functions relating to measurement, assessment and improvement of patient care process delegated to the Medical Staff, including their composition, duties, and reporting requirements, is contained in the Medical Staff Organization and Functions Manual. At a minimum, the Medical Staff shall carry out the following functions:

1. performance improvement evaluation;
2. medical assessment and treatment of patients;
3. use of operative and other procedures;
4. use of medications;
5. medical records review;
6. use of blood and blood components;
7. pharmacy and therapeutics review;
8. risk management;
9. significant departures from established patterns of clinical practice;
10. infection control review;
11. education of patients and family;
12. efficiency of clinical practice patterns;
13. coordination of care with other practitioners and hospital personnel as relevant to individual patients
14. utilization review; and
15. hospital safety, including disaster planning.

## ARTICLE IX – PART F: SPECIAL COMMITTEES

Special committees shall be created, and their members and chairpersons shall be appointed, by the President of the Medical Staff with the approval of the Board as required. Such committees shall confine their activities to the purpose for which they were appointed, and shall report to the MEC.

# ARTICLE XRULES OF THE MEDICAL STAFF

## ARTICLE X – PART A: ADOPTION

Medical Staff rules, as may be necessary to implement more specifically the general principles of conduct found in these bylaws, shall be adopted in accordance with this Article X. Rules shall set standards of practice that are to be required of each individual exercising clinical privileges in the Hospital, and shall act as an aid to evaluating performance under, and compliance with, these standards. Rules shall have the same force and effect as the bylaws.

## ARTICLE X – PART B: AMENDMENT

### Section 1. Rules Applicable at Hospital and St. Joseph’s Hospital

Rules applicable at both Hospital and St. Joseph’s Hospital may be amended upon approval of both MECs by a majority vote of the members present and voting at any meeting of the MECs where a quorum exists provided that the proposed amendment has been communicated to the Medical Staff for review and comment at least 14 days prior to the MEC vote. No such amendment shall be effective unless and until it has been approved by both MECs and by both Boards.

**ARTICLE X – PART B: AMENDMENT**

## The MEC(s) shall have the power to adopt such urgent amendments to the Rules & Regulations which are, in the committee's judgment, technical or legal modifications or clarifications, reorganization or renumbering, or amendments made necessary because of punctuation, spelling, or other errors of grammar or expression. Such amendments shall be effective immediately and shall be permanent if not disapproved by the Medical Staff or the Board within 60 days of adoption by the MEC. The action to amend may be taken by a motion acted upon in the same manner as any other motion before the MEC. Immediately upon adoption, such amendments shall be sent to the President of the Hospital and posted on the Medical Staff bulletin board for fourteen (14) days. RULES APPLICABLE AT ST. JOSEPH’S HOSPITAL ONLY

### Section 2. Urgent Amendments

The MEC shall have the power to adopt such urgent amendments to Rules which are, in the judgment of the MEC, technical or legal modifications or clarifications, reorganization or renumbering, or amendments made necessary because of punctuation, spelling, or other errors of grammar or expression. Such amendments shall be effective immediately and shall be permanent if not disapproved by the Medical Staff or the Board within 60 days of adoption by the MEC. The action to amend may be taken by a motion acted upon in the same manner as any other motion before the MEC. Immediately upon adoption, such amendments shall be sent to the President of the Hospital and posted on the Medical Staff bulletin board for fourteen (14) days.

**ARTICLE X – PART B: AMENDMENT**

## RULES APPLICABLE AT ST. JOSEPH’S HOSPITAL ONLY

###  Section 3. Rules Applicable at Hospital

Rules that are applicable at Hospital only may be amended by a majority vote of the members of the Hospital’s MEC present and voting at any meeting where a quorum exists; provided that the proposed amendment has been communicated to the Medical Staff for review and comment at least 14 days prior to the MEC vote. No such amendment shall be effective unless and until it has been approved by the Board.

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# ARTICLE XIAMENDMENTS

## ARTICLE XI – PART A: SUBSTANTIVE AMENDMENTS

### Section 1. MEC Consideration and Staff Vote

All proposed amendments of these bylaws initiated by the Medical Staff shall, as a matter of procedure, be referred to the MEC. Amendments shall then be effectuated in one of two ways:

1. The MEC shall report on the proposed amendments either favorably or unfavorably at the next regular meeting of the Medical Staff, or at a special meeting called for that purpose. They shall be voted upon at that meeting provided that they have been posted on the Medical Staff bulletin board at least 14 days prior to the meeting. To be adopted, an amendment must receive a majority of the votes cast by the voting Staff who are present at the time of such vote and who do vote; or
2. Proposed amendments may also be presented to the voting Staff by mail or by electronic delivery. Along with the proposed amendments, the MEC may, in its discretion, provide a written report on them either favorably or unfavorably. In addition, the proposed amendment shall be posted on the Medical Staff bulletin board at least 14 days prior to the return date requested for the vote. To be adopted, an amendment must receive a majority of the votes cast, so long as the amendment is voted on by ten percent (10%) the Staff eligible to vote.

**ARTICLE XI – PART A: SUBSTANTIVE AMENDMENTS**

### Section 2. Board Approval

All substantive amendments to these bylaws shall become effective when approved by the Board.

## ARTICLE XI – PART B: TECHNICAL AMENDMENTS

The MEC shall have the power to adopt such amendments to the bylaws as are, in the committee's judgment, technical or legal modifications or clarifications, reorganization or renumbering, or amendments made necessary because of punctuation, spelling, or other errors of grammar or expression. Such amendments shall be effective immediately and shall be permanent if not disapproved by the Medical Staff or the Board within 60 days of adoption by the MEC. The action to amend may be taken by a motion acted upon in the same manner as any other motion before the MEC. Immediately upon adoption, such amendments shall be sent to the President of the Hospital and posted on the Medical Staff bulletin board for fourteen (14) days.

## ARTICLE XI – PART C: LEGAL REVIEW

All proposed changes to the bylaws shall be given to the Hospital’s General Counsel as early as possible so that they can be reviewed to determine whether there is a conflict between the proposed bylaws and the Hospital’s bylaws. If there is a conflict, the General Counsel shall recommend changes and work with the MEC to eliminate the conflict before the vote of the MEC and the Board.

## ARTICLE XI – PART D: JOINT CONFERENCE

If the Board has determined not to accept a recommendation submitted to it by the MEC, the MEC is entitled to a joint Conference between the officers of the Board and the officers of the Medical Staff. Such Joint Conference shall be for purposes of further communicating the Board’s rationale for its contemplated action, and to permit the officers of the Medical Staff to fully articulate the rationale for the MEC’s recommendation. The President of the Hospital will schedule such a Joint Conference within two weeks after receipt of a request for a Joint Conference submitted by the President of the Medical Staff.

Date approved by Medical Staff: 11/03/2023

Date approved by Board (Consent in Lieu): 11/14/2023

1. The National Disaster Medical System (NDMS), under the auspices of the U. S. Public Health Service (PHS), develops and organizes DMATs, which are groups of professional medical personnel designated to provide emergency medical care during a disaster. DMATs deploy to disaster sites with medical supplies and equipment to sustain themselves for a 72-hour period while providing care at a fixed or temporary medical care site. The PHS issues ID cards to all DMAT members every two years. The card includes a picture of the cardholder, expiration date, and DMAT team name. The PHS and National Disaster Medical System insignias appear on the front of the card. [↑](#footnote-ref-1)